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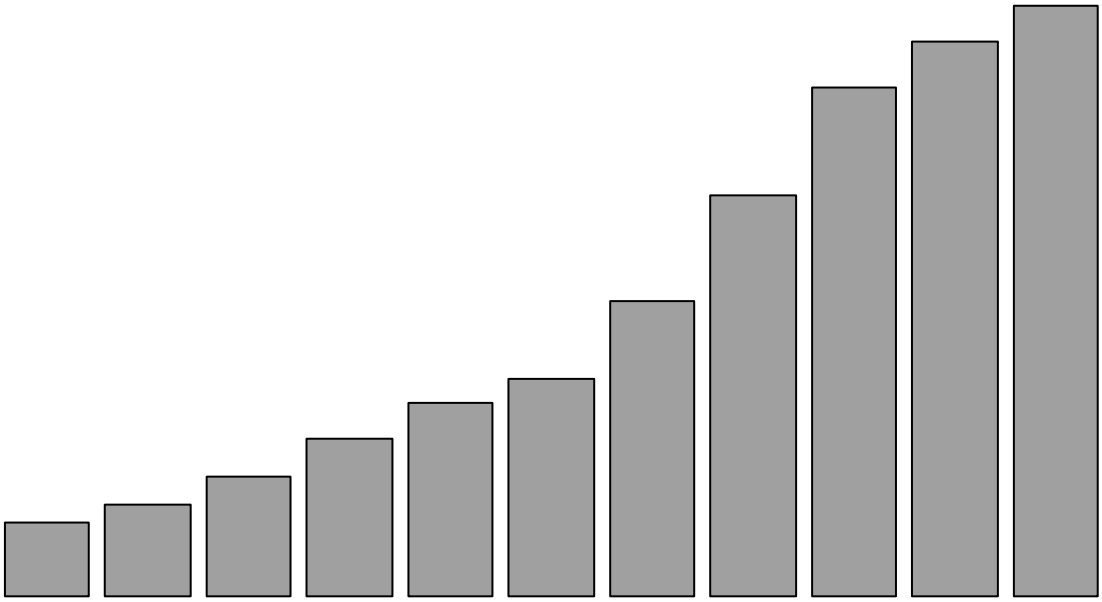

California State Plan on Aging 2005-2009

CALIFORNIA STATE PLAN ON AGING
2005-2009

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Section I Introduction

Background

Every four years each State Unit on Aging is required by federal law to submit a State Plan on Aging. At a minimum, this Plan must specify:

- The State's goals and objectives for the four year period;
- Statewide program objectives to implement the requirements under Title III of the Older Americans Act (OAA);
- A resource allocation plan indicating the proposed use and the distribution of Title III funds to each Planning and Service Area (PSA);
- The geographic boundaries of each PSA and of the Area Agency on Aging (AAA) designated for each PSA;
- The prior federal fiscal year information on low income, minority and rural older adults; and
- Compliance with assurances currently required by the OAA of 1965, as amended in 2000 (P.L. 106-501) and Section 1321.17(f) beginning at (f)(1).

The State Plan on Aging is submitted to the federal Administration on Aging (AoA) in compliance with federal law regulations. When approved, the State of California receives federal funds to administer the State Plan. These federal funds are matched with State and local funds.

Beyond the minimum required information, California's 2005-2009 State Plan on Aging addresses:

- Key socio-demographic factors that will shape funding needs and priorities;
- Priorities, unmet needs and promising practices identified by CDA and the AAAs; and
- CDA's objectives in working with the AAAs to provide cost-effective, high quality services to California's older adults and their informal caregivers.

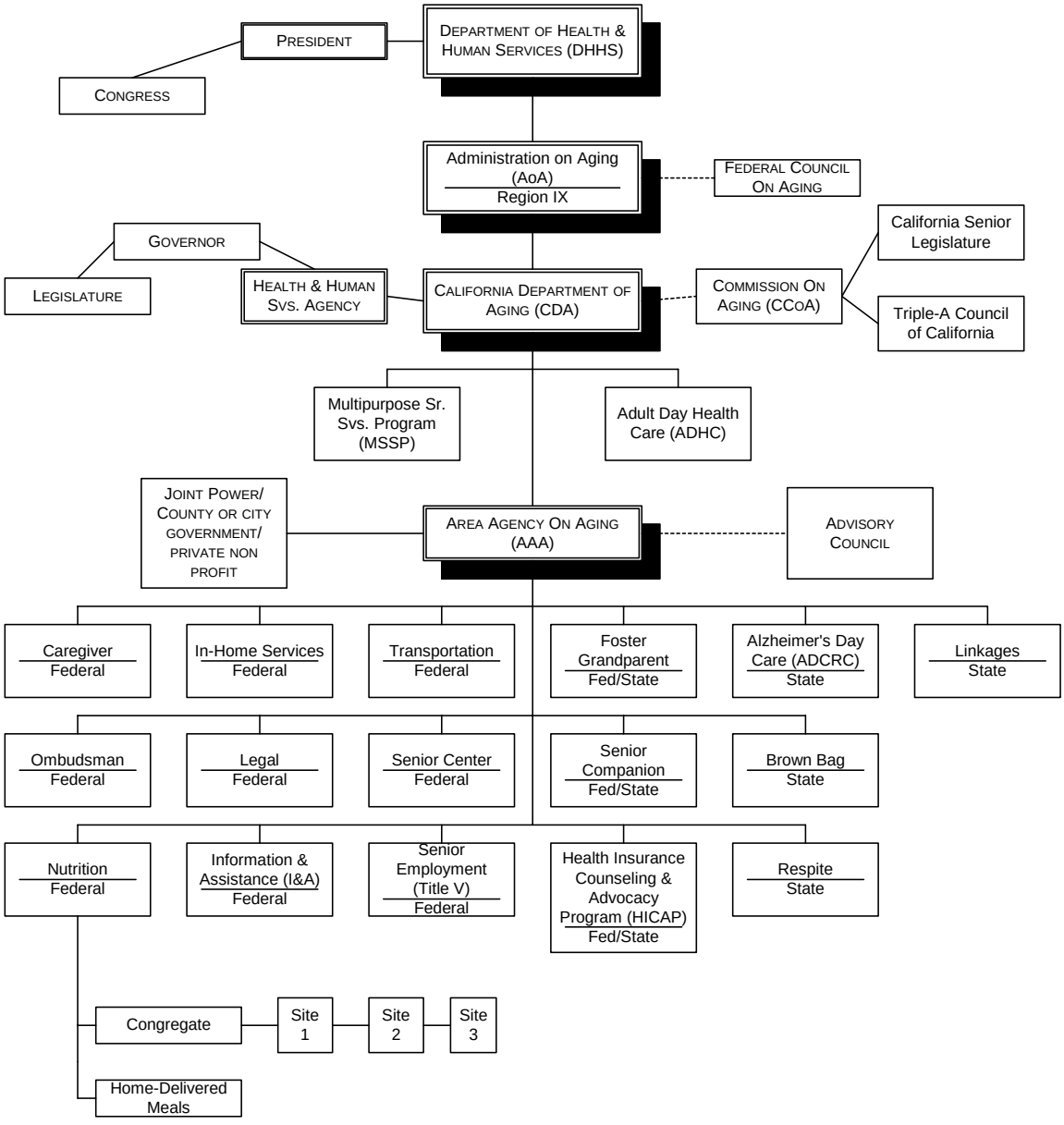
In addition to OAA programs, CDA and AAAs administer a variety of home and community-based services authorized in the Older Californians Act (OCA), which serve older adults and one program that serves adults all ages with disabilities (i.e. Linkages) (See Figure 1). CDA also administers the Multipurpose Senior Services Program (MSSP), the Medi-Cal waiver for older adults, and certifies adult day health care (ADHC) centers for Medi-Cal reimbursement. ADHCs serve older adults as well as younger adults with disabilities. Medi-Cal programs are jointly funded with federal and state dollars.

Objectives for these programs have also been included in this State Plan because CDA plans to coordinate these key activities across the Department regardless programmatic and funding "silos." For example, CDA plans to address quality improvement across all programs. The Department will also include the assessment of caregiver needs into

programs that previously have focused only on the needs of older clients. These examples apply across all of CDA's OAA, OCA and Medi-Cal funded programs.

Figure 1

NETWORK OF AGING SERVICES



Report Terminology

Because eligibility for OAA services is limited to older adults and family caregivers and the majority of the other programs administered by CDA are limited to older adults, most

references in this Plan will be to clients who are older adults, unless otherwise specified. The term “caregiver” in California is often used to refer to paid individuals (including relatives), who deliver services in the home, in a day care center or in a facility. However, because the OAA Family Caregiver Support Program (FCSP) focuses specifically on supporting families, neighbors and friends in their caregiving efforts, in this Plan the term “caregiver” will refer to the unpaid informal assistance provided by these individuals.

In Section V (Past Accomplishments and Future Priorities), the Plan refers to “business partners” and “contractors.” CDA’s key business partners include the AAAs and MSSP sites with whom the Department contracts directly. CDA’s business relationship with ADHC centers is based on the Medi-Cal certification the Department performs through an Interagency Agreement with the DHS Medi-Cal Program, as authorized in statute. CDA also has additional contractual relationships with other organizations to perform special time limited federal grants or more focused contracts pertaining to a specific CDA business need. All of these contractual relationships are critical in assisting CDA to fulfill its mission and goals.

While the OAA and CMS Medi-Cal waiver programs use the term “case” management, this term is widely disliked by disability advocates who prefer terms and service models that emphasize the active involvement of the client in managing his/her own services to the fullest extent possible. As a compromise, this Plan uses the term “care” management rather than “case” management, although “service coordination” would be preferable to disability advocates.

And finally, some of the priorities in Section V refer to “elder and dependent adult abuse.” The term “dependent adult” is not commonly used today in reference to persons with disabilities. However it is the legal term used in the California Welfare and Institutions Code Section 15600 pertaining to reporting of abuse or neglect against older adults and adults with disabilities. So in reference to those issues, this terminology is used.

For readers not familiar with the Older Americans Act and its specific program sections, (e.g. Title I, II, III, etc.) a listing of the relevant titles and the programs provided under those sections is listed in Appendix A.

California Strategic Planning on Aging Issues

Over the past several years, a number of strategic planning documents on the aging of California’s population have been developed. Senate Bill 910 (Chapter 948 Statutes of 1999) required the California HHS Agency to prepare a Strategic Plan on Aging. To inform that process, the University of California produced a number of issues papers on key aging policy concerns. Most recently, the California Assembly Committee on Aging and Long-Term Care (LTC) developed several relevant issue papers. The SB 910 Strategic Plan on Aging had sizeable stakeholder participation and a public hearing process. Review and input to the current Assembly proposals continues. This Plan

draws from the findings in these reports and does not attempt to duplicate those significant efforts.

Link to California Olmstead Planning

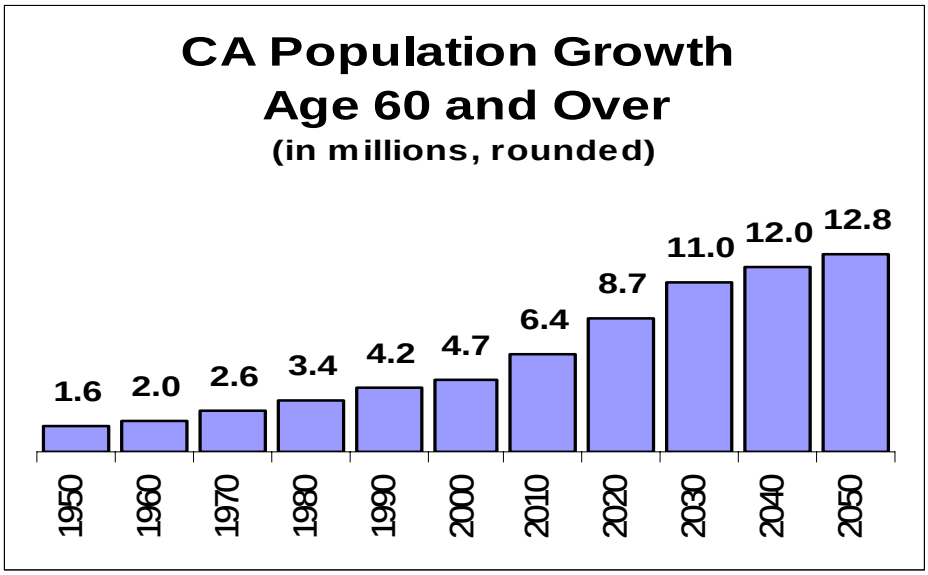
This State Plan will also be presented to the California Health and Human Services (HHS) Agency's Olmstead Advisory Committee to inform the overall state efforts to continue to expand community support options for individuals in or at risk of institutional placement and their families.

Section II Aging California

Overview

California's population age 60 and over has grown rapidly throughout this century (see Table 1). Between 1950 and 2000, older adults in this state increased from 1.6 million to 4.7 million, an increase of 194 percent. This trend will continue as the cohort age 60 and over grows to 12.8 million by 2050, an increase of 172 percent from 2000.

Table 1



The largest growth rate will occur during the next 30 years as the Baby Boomers, those born between 1946 and 1964, reach age 60. The first wave of Baby Boomers will turn 60 between 2000 and 2010, contributing to a 36 percent increase in California's older adult population during this decade. By 2010, nearly 16 percent of Californians will be age 60 or older.

While the overall population age 60 and over is growing rapidly, increases within this age group are occurring at different rates. In 2000, approximately 1.1 million Californians were between the ages of 60-64. By 2040 that age group is projected to grow to 2.6 million, a 125% increase. While the group age 85 and over included only 425,000 individuals in 2000, that group will likely increase 205 percent, to 1.3 million by 2040 (see Table 2).

The current size of the population age 85 and over, and the projected increase in this cohort, is notable because this age group has a significantly higher rate of severe chronic health conditions and functional limitations, resulting in the need for more health and supportive services. The rapid growth of this age group has many implications for individuals, families, communities and government.

Table 2
Projected Growth in Population Age 60 and Over, 2000-2040 by Age Groups

Age Range	Total Population (2000 Census)	Total Population (2010 DoF Projections)	Total Population (2040 DoF Projections)	Total Population Change	Percent Change
60-64	1,146,841	1,944,211	2,579,283	1,432,442	125%
65-69	984,535	1,388,990	2,488,577	1,504,042	153%
70-74	903,288	1,033,176	2,286,549	1,383,261	153%
75-79	779,347	799,244	1,960,630	1,181,283	152%
80-84	502,831	615,927	1,430,462	927,631	184%
85+	425,657	629,241	1,297,890	872,233	205%
Totals	4,742,499	6,410,789	12,043,391	7,300,892	154%

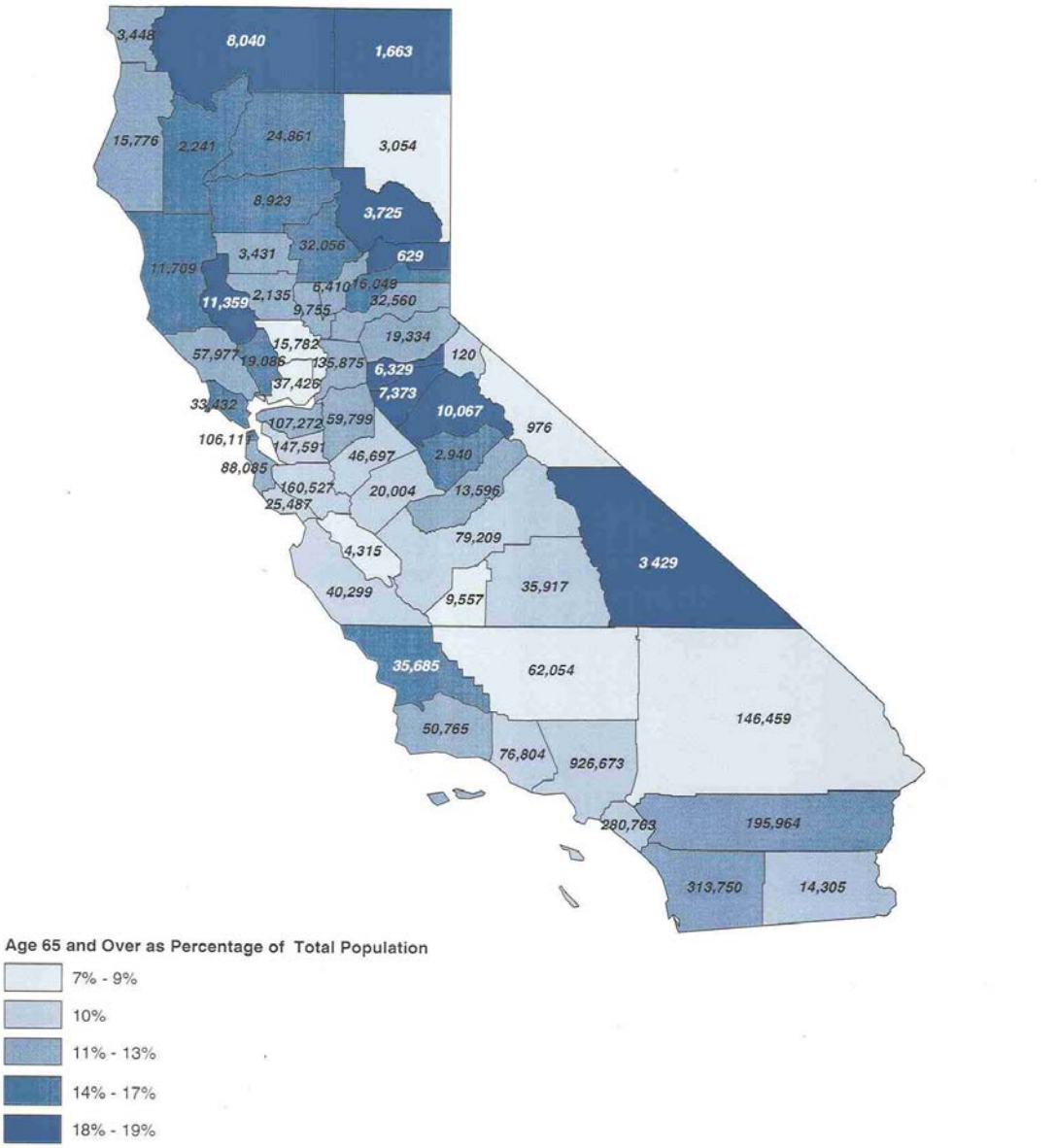
Source: State of California, Department of Finance. *Race/Ethnic Population with Age and Sex Detail, 2000-2050*, Sacramento, CA. May 2004.

Currently, this State and the nation are experiencing a slight, temporary decline in the percentage of older adults, caused by the relatively small number of people born during the Great Depression and World War II, who are now reaching their mid- to late 60s and 70's. But this represents a relatively short interval to plan for the dramatic growth of Californians population age 60 and over. The impact of anticipated population increase, which has been described by some as an "age wave" and by others as an "aging tsunami," will be felt in every aspect of society.

The economic, housing, transportation, health and social support implications of this aging phenomenon must also be viewed in the context of the State's tremendous overall population growth, which continues to challenge the State's overall infrastructure planning. Demographers project that California's population, now 36 million, could reach 55 million by 2050, given trends in birth, death and migration rates.

California's birth rate is projected to remain relatively high, compared to many other states. As a result, in 2000, adults age 60 and over comprised 14 percent of the State's population, compared to the 16.3 percent nationwide. However, the ratio of Californians age 60 and over will likely increase to 20 percent by 2020 compared to 23.4 percent nationwide.

Figure 2
Californians Age 65 and Over as a Percent of Total Population



While California today may be a relatively young compared to many other states, the ratio of older to younger Californians differs greatly across California's counties (see

Figure 2). In the rural Sierra and far northern areas, those age 65 and over represented approximately 19% of those counties' population in 2000. This age concentration is generally caused by two factors. First, retirees move to more rural areas, drawn by housing affordable and picturesque, vacation-type locations. Second, traditional economies in these areas may not have provided sufficient employment opportunities, so younger residents who grew up in these areas often migrate to more urban counties or other states.

Meanwhile, other counties have a much younger overall population. While the largest number of older adults live in Los Angeles and San Diego, older adults represented only 9 percent and 11 percent of the total population respectively in those counties in 2000.

Between 2005 and 2020, the percent of Californians age 60 and over is projected to increase by 59% from 5.5 million to 8.7 million. However, 13 of California's PSAs, particularly those in some rural areas, are expected to have less than that amount of growth, while others are projected to have much higher levels of growth. (See Table 3.)

Table 3

California Projected Population Age 60 and Over
Percentage Change Between 2005 and 2020
By Planning and Service Areas (PSAs) and Counties

	2005 60+ TOTAL POPULATION	2020 60+ TOTAL POPULATION	Difference	% Change
CALIFORNIA	**5,507,167**	**8,742,296**	**3,235,129**	**59%**
PSA 1				
DEL NORTE	5,047	7,642	2,595	51%
HUMBOLDT	22,221	34,744	12,523	56%
TOTAL	**27,268**	**42,386**	**15,118**	**55%**
PSA 2				
LASSEN	**4,858**	**7,836**	**2,978**	**61%**
MODOC	2,415	2,964	549	23%
SHASTA	40,761	56,212	15,451	38%
SISKIYOU	11,682	16,140	4,458	38%
TRINITY	3,576	4,575	999	28%
TOTAL	**63,292**	**87,727**	**24,435**	**39%**
PSA 3				
BUTTE	45,077	71,489	26,412	59%
COLUSA	3,069	4,737	1,668	54%
GLENN	4,949	6,579	1,630	33%
PLUMAS	5,801	7,205	1,404	24%
TEHAMA	13,583	16,126	2,543	19%
TOTAL	**72,479**	**106,136**	**33,657**	**46%**
PSA 4				
NEVADA	22,306	31,087	8,781	39%
PLACER	56,574	107,886	51,312	91%

	2005 60+ TOTAL POPULATION	2020 60+ TOTAL POPULATION	Difference	% Change
SACRAMENTO	202,356	336,391	134,035	66%
SIERRA	969	1,232	263	27%
SUTTER	14,517	21,608	7,091	49%
YOLO	24,130	44,061	19,931	83%
YUBA	9,906	15,061	5,155	52%
TOTAL	**330,758**	**557,326**	**226,568**	**68%**
PSA 5				
MARIN	**52,045**	**79,359**	**27,314**	**52%**
PSA 6				
SAN FRANCISCO	**144,080**	**206,176**	**62,096**	**43%**
PSA 7				
CONTRA COSTA	**160,913**	**267,728**	**106,815**	**66%**
PSA 8				
SAN MATEO	**124,356**	**190,887**	**66,531**	**54%**
PSA 9				
ALAMEDA	**210,954**	**361,799**	**150,845**	**72%**
PSA 10				
SANTA CLARA	**256,552**	**428,354**	**171,802**	**67%**
PSA 11				
SAN JOAQUIN	**87,033**	**148,661**	**61,628**	**71%**
PSA 12				
ALPINE	261	550	289	111%
AMADOR	9,502	13,652	4,150	44%
CALAVERAS	12,259	19,884	7,625	62%
MARIPOSA	4,627	6,341	1,714	37%
TUOLUMNE	14,259	19,583	5,324	37%
TOTAL	**40,908**	**60,010**	**19,102**	**47%**
PSA 13				
SAN BENITO	6,997	13,232	6,235	89%
SANTA CRUZ	37,979	69,038	31,059	82%
TOTAL	**44,976**		**37,294**	**83%**
PSA 14				
FRESNO	115,060	181,451	66,391	58%
MADERA	21,708	33,200	11,492	53%
TOTAL	**136,768**	**214,651**	**77,883**	**57%**
PSA 15				
KINGS	15,522	27,276	11,754	76%
TULARE	50,657	79,080	28,423	56%
TOTAL	**66,179**	**106,356**	**40,177**	**61%**
PSA 16				
INYO	4,794	5,747	953	20%
MONO	2,030	4,056	2,026	100%
TOTAL	**6,824**	**9,803**	**2,979**	**44%**
PSA 17				
SAN LUIS OBISPO	52,638	88,895	36,257	69%
SANTA BARBARA	67,795	89,707	21,912	32%

	2005 60+ TOTAL POPULATION	2020 60+ TOTAL POPULATION	Difference	% Change
TOTAL	**120,433**	**178,602**	**58,169**	**48%**
	2005 60+ TOTAL POPULATION	**2020 60+ TOTAL POPULATION**	**Difference**	**% Change**
PSA 18				
VENTURA	**129,208**	**224,029**	**94,821**	**73%**
PSA 19				
LOS ANGELES CO.*	**1,469,123**	**2,168,448**	**699,325**	**48%**
PSA 20				
SAN BERNARDINO	**232,268**	**404,655**	**172,387**	**74%**
PSA 21				
RIVERSIDE	**317,113**	**503,456**	**186,343**	**59%**
PSA 22				
ORANGE	**437,972**	**719,037**	**281,065**	**64%**
PSA 23				
SAN DIEGO	**441,298**	**695,963**	**254,665**	**58%**
PSA 24				
IMPERIAL	**21,516**	**35,969**	**14,453**	**67%**
PSA 25				
LOS ANGELES CITY[1]	**0**	**0**	**0**	
PSA 26				
LAKE	15,705	21,460	5,755	37%
MENDOCINO	17,495	25,876	8,381	48%
TOTAL	**33,200**	**47,336**	**14,136**	**43%**
PSA 27				
SONOMA	**87,780**	**162,982**	**75,202**	**86%**
PSA 28				
NAPA	27,114	40,257	13,143	48%
SOLANO	66,668	118,635	51,967	78%
TOTAL	**93,782**	**158,892**	**65,110**	**69%**
PSA 29				
EL DORADO	**31,517**	**58,629**	**27,112**	**86%**
PSA 30				
STANISLAUS	**70,227**	**114,227**	**44,000**	**63%**
PSA 31				
MERCED	**29,886**	**49,099**	**19,213**	**64%**
PSA 32				
MONTEREY	**58,236**	**92,403**	**34,167**	**59%**
PSA 33				
KERN	**108,223**	**178,940**	**70,717**	**65%**

*Los Angeles County is divided into two PSAs: PSA 19 and PSA 25. PSA 25 includes the City of Los Angeles. PSA 19 consists of the remaining portions of Los Angeles County. Separate data for the City of Los Angeles is not available.

Projections also indicate that by 2020, many counties will see a moderate to substantial decrease in their older adult population age 85 and over. By 2020, 36 counties will likely experience decreases ranging from 2 percent to 92 percent, while 22 counties will have an increase in older adults (see Table 4). The greatest areas of older adult population growth are projected to be concentrated in Riverside and San Bernardino counties, with increases of 54 percent and 42 percent respectively.

Table 4

California Projected Population Age 85 and Over
Percentage Change between 2005 AND 2020
by Planning and Service Areas (PSAs) and Counties

	2005 85+ TOTAL POPULATION	2020 85+ TOTAL POPULATION	Difference	% Change
CALIFORNIA	**639,146**	**679,366**	**40,220**	**6%**
PSA 1				
DEL NORTE	1,979	719	(1,260)	-64%
HUMBOLDT	3,632	2,539	(1,093)	-30%
TOTAL	**5,611**	**3,258**	**(2,353)**	**-42%**
PSA 2				
LASSEN	1,961	643	(1,318)	-67%
MODOC	1,706	336	(1,370)	-80%
SHASTA	7,924	10,042	2,118	27%
SISKIYOU	2,559	1,532	(1,027)	-40%
TRINITY	1,787	486	(1,301)	-73%
TOTAL	**15,937**	**13,039**	**(2,898)**	**-18%**
PSA 3				
BUTTE	5,175	5,677	502	10%
COLUSA	1,796	420	(1,376)	-77%
GLENN	1,983	607	(1,376)	-69%
PLUMAS	2,031	892	(1,139)	-56%
TEHAMA	3,433	2,327	(1,106)	-32%
TOTAL	**14,418**	**9,923**	**(4,495)**	**-31%**
PSA 4				
NEVADA	3,599	2,261	(1,338)	-37%
PLACER	7,191	9,514	2,323	32%
SACRAMENTO	22,393	25,089	2,696	12%
SIERRA	1,578	119	(1,459)	-92%
SUTTER	2,827	1,914	(913)	-32%
YOLO	3,743	2,679	(1,064)	-28%
YUBA	2,324	1,417	(907)	-39%
TOTAL	**43,655**	**42,993**	**(662)**	**-2%**
PSA 5				
MARIN	**6,524**	**4,967**	**(1,557)**	**-24%**
PSA 6				
SAN FRANCISCO	**17,425**	**19,711**	**2,286**	**13%**

	2005 85+ TOTAL POPULATION	2020 85+ TOTAL POPULATION	Difference	% Change
PSA 7				
CONTRA COSTA	**18,372**	**18,917**	**545**	**3%**
PSA 8				
SAN MATEO	**14,449**	**14,142**	**(307)**	**-2%**
PSA 9				
ALAMEDA	**21,311**	**24,656**	**3,345**	**16%**
PSA 10				
SANTA CLARA	**23,412**	**28,793**	**5,381**	**23%**
PSA 11				
SAN JOAQUIN	**9,541**	**8,937**	**(604)**	**-6%**
PSA 12				
ALPINE	26	76	50	192%
AMADOR	711	1,011	300	42%
CALAVERAS	2,248	1,188	(1,060)	-47%
MARIPOSA	1,850	607	(1,243)	-67%
TUOLUMNE	2,726	1,739	(987)	-36%
TOTAL	**7,561**	**4,621**	**(2,940)**	**-39%**
PSA 13				
SAN BENITO	2,045	868	(1,177)	-58%
SANTA CRUZ	5,566	3,975	(1,591)	-29%
TOTAL	**7,611**	**4,843**	**(2,768)**	**-36%**
PSA 14				
FRESNO	13,040	13,575	535	4%
MADERA	4,224	5,081	857	20%
TOTAL	**17,264**	**18,656**	**1,392**	**8%**
PSA 15				
KINGS	2,828	1,868	(960)	-34%
TULARE	5,793	5,628	(165)	-3%
TOTAL	**8,621**	**7,496**	**(1,125)**	**-13%**
PSA 16				
INYO	2,086	661	(1,425)	-68%
MONO	1,564	210	(1,354)	-87%
TOTAL	**3,650**	**871**	**(2,779)**	**-76%**
PSA 17				
SAN LUIS OBISPO	6,547	6,279	(268)	-4%
SANTA BARBARA	9,003	7,466	(1,537)	-17%
TOTAL	**15,550**	**13,745**	**(1,805)**	**-12%**
PSA 18				
VENTURA	**14,328**	**17,365**	**3,037**	**21%**
PSA 19				
LOS ANGELES CO.*	**158,364**	**154,181**	**(4,183)**	**-3%**
PSA 20				
SAN BERNARDINO	**20,116**	**28,604**	**8,488**	**42%**
PSA 21				
RIVERSIDE	**30,462**	**46,766**	**16,304**	**54%**
PSA 22				

	2005 85+ TOTAL POPULATION	2020 85+ TOTAL POPULATION	Difference	% Change
ORANGE	**40,444**	**48,981**	**8,537**	**21%**
PSA 23				
SAN DIEGO	**45,503**	**51,801**	**6,298**	**14%**
PSA 24				
IMPERIAL	**3,064**	**3,222**	**158**	**5%**
PSA 25				
LOS ANGELES CITY*	**0**	**0**	**0**	
PSA 26				
LAKE	2,977	1,902	(1,075)	-36%
MENDOCINO	3,091	1,937	(1,154)	-37%
TOTAL	**6,068**	**3,839**	**(2,229)**	**-37%**
PSA 27				
SONOMA	**13,367**	**21,030**	**7,663**	**57%**
PSA 28				
NAPA	5,324	4,440	(884)	-17%
SOLANO	11,501	14,973	3,472	30%
TOTAL	**16,825**	**19,413**	**2,588**	**15%**
PSA 29				
EL DORADO	**3,927**	**3,346**	**(581)**	**-15%**
PSA 30				
STANISLAUS	**9,173**	**9,542**	**369**	**4%**
PSA 31				
MERCED	**3,889**	**3,650**	**(239)**	**-6%**
PSA 32				
MONTEREY	**6,990**	**6,803**	**(187)**	**-3%**
PSA 33				
KERN	**15,714**	**21,255**	**5,541**	**35%**

While Table 5 presents an overview of older Californians today, older adults have never been a heterogeneous group in terms of educational achievement, income level, and health and disability status. In the coming decades, the gap between have's and the have not's among older Californians will grow even wider. Educational and employment opportunities throughout life impact access to health care, retirement savings and pension benefits in later life. The cumulative effect of all these factors shape older Californians' prospects for a healthy and secure retirement. Important differences among the state's older adults are tied to racial, ethnic and cultural factors; gender and marital status; geographic location and socio-economic resources.

Table 5
A Snapshot of Older Californians Age 65+, 2000

With high school diploma or higher [1]	70.1%
Limited English proficiency [2]	16.9%
Medi-Cal beneficiaries [2]	20%
Below poverty level [2]	8.1%
Poor or near poor (0-199% of poverty) [2]	28.6%
Homeowners[5]	74.5%
Living alone [2]	26%
Women age 65+ living alone [6]	31.4%
Living in a nursing home [2]	3.2%
Number of grandparents responsible for basic needs of grandchildren [3]	294,969
Proportion of Californians age 75 and older with a driver's license [4]	59.6%
Percent with any disability [2]	42.2%

Race, ethnicity and cultural factors

In the late 1990s, California's White, Non-Latino population became a minority group for the first time since before the 1849 Gold Rush. California's older adults are and will continue to grow ethnically and culturally diverse. While 64 percent of older adults are White/Non-Latino today, by 2040 the majority will be from groups now considered to be ethnic minorities (See Table 6).

Table 6
California's Projected Population Age 60+ as a Percent of Total Population by Race and Ethnicity

Racial/Ethnic Group	2005	2010	2020	2030	2040
White/Non-Hispanic	64.2%	60%	52.7%	44%	36.1%
Hispanic/Latino	16.6%	18.8%	23.5%	30%	37.5%
Asian	11.6%	13%	14%	15.6%	16.8%
Black/African American	5.5%	5.6%	5.7%	5.7%	5.3%
Multiracial	1.1%	1.3%	1.5%	1.6%	1.6%
American Indian/Alaska Native	0.7%	0.8%	1.2%	1.5%	1.8%
Native Hawaiian/Other Pacific Islander	0.2%	.3%	.3%	.4%	.5%

Source: State of California, Department of Finance. *Race/Ethnic Population with Age and Sex Detail, 2000-2050*, Sacramento, CA. May 2004.

Ethnic and cultural diversity has enriched California, fostered new innovations, and encouraged an appreciation of the State's multicultural traditions as well as the values and priorities we hold in common. However, because some groups have been historically deprived of opportunities or are now faced with the challenges of life in a

new culture, diversity may translate into health and economic disparities that must be addressed.

- All ethnic older adults report poor or fair health more often than non-Latino whites. Older Latinos and those with limited-English abilities have the worst health profiles compared to statewide averages.[2]

- While 74 percent of native-born older Californians have at least 12 years of education, only about 50 percent of older immigrants have this level of education.

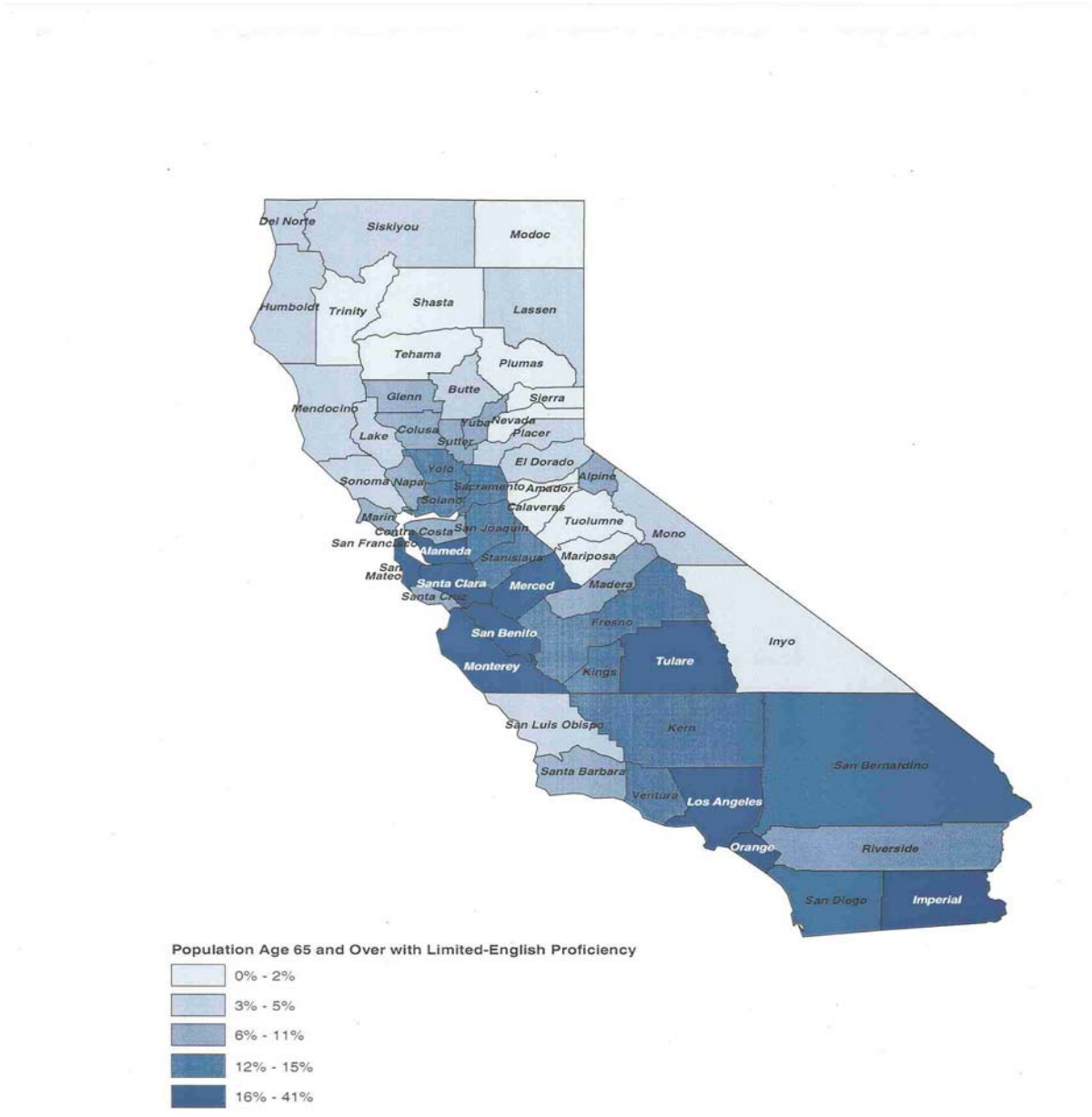
- Cultural customs and expectations related to a family's care giving responsibilities can have a significant negative impact on the primary caregiver's health and future financial resources.[7]

Between 1995 and 2000, 128,728 residents age 65 and older migrated out of California, while 94,557 residents from other states migrated into the state. An additional 53,000 individuals migrated to California from abroad.[8] About 20% of California's older adults are immigrants from other counties. Of these, almost two-thirds arrived before the 1980s, less than a quarter arrived in the 1980s, and one-tenth arrived after 1990. The future size and age distribution of the California population will also be influenced by both international and domestic migration, both of which are difficult to predict."[9]

While approximately 17 percent of older Californians have limited English proficiency, in Alameda, San Francisco, Santa Clara, Merced, San Benito, Monterey, Tulare, Los Angeles, Orange and Imperial counties between 16 and 41 percent of older adults have difficulties in communicating in English (see Figure 3).

Providing culturally appropriate outreach and assistance is essential in overcoming disparities in accessing health and social services. However, addressing these linguistic and cultural issues adds to the complexity and costs involved in serving these older adults.

Figure 3
California Population Age 65 and Over with Limited English Proficiency



Over the past decade, the unique issues California's aging gay men and lesbians have experienced are increasingly being discussed and addressed. While gay and lesbian elders are as diverse as their heterosexual counterparts, the experience or fear of discrimination across their lifetime has caused some of these elders to remain invisible, preferring to go without much needed social, health and mental health services. It is difficult to estimate the number of gay men and lesbians in the population, but several

current studies estimate that 3 to 8 percent of the population is gay or lesbian.[10] Although this overall estimate may underestimate California's gay and lesbian population, this would translate to 165,000 to 441,000 older Californians who are gay or lesbian.

Gender and Marital Status

On average, women live six or seven years longer than men. Of the population between the ages of 65 and 84, 56% are women. Beyond age 85, 60% are women. Owing to their longer life expectancy and their tendency to marry men who are two or three years older than they are, women have a much higher probability of losing their spouse than men do. While 27% of all those between age 65 and 84 have lost a spouse, 61% of those age 85 and older have done so. Over age 65, older women outnumber men at a rate of 3 to 2. This gap increases with age, so that women make up almost 85% of those over age 100.

Women become more vulnerable as they grow older, because they are more likely than men to live alone, be (or become) poor, and have multiple chronic health conditions.[9] Significant differences in poverty are related to gender. In 1997, 7 percent of older American men were poor, compared to 13 percent of older women and 18 percent of older widows.[16.] In retirement, older women are at greater economic risk than men due to income gaps. In 1993, for example, women age 65 and over had a median annual income that was 57 percent that of their male peers. In 1995, the average Social Security benefit for women was $538 per month compared with $858 for men. Not only are women's Social Security payments less than men's, but such payments are likely to be their only source of income. Economic disparities based on gender may decrease in the future as more women receive higher retirement income benefits from Social Security, pensions and other retirement savings. However, the women most likely to have increased income in retirement will be wealthier baby boomers, who are likely to be white, and poorer women, will likely continue to be women of color.

Geographic Location

The Los Angeles Basin and the San Francisco Bay Area are now home to about two-thirds of the state's older population and that will likely continue over the next 40 years. While every region, except the most rural areas of the state, is expected to experience strong growth in its 60+ population, the largest increases are predicted for the Los Angeles Basin and the San Joaquin Valley, where the number of older people is expected to almost triple by 2040.[9]

Currently, the age dependency ratio does not vary much by region. The exception is the Sacramento Valley-North Coast-Mountain region, which has 25 seniors per 100 working-age adults compared to the state average of 18 per 100. By 2040, the rapidly aging Bay Area population is projected to become the oldest area of the state, with 41 older adults per 100 working-age adults. [9]

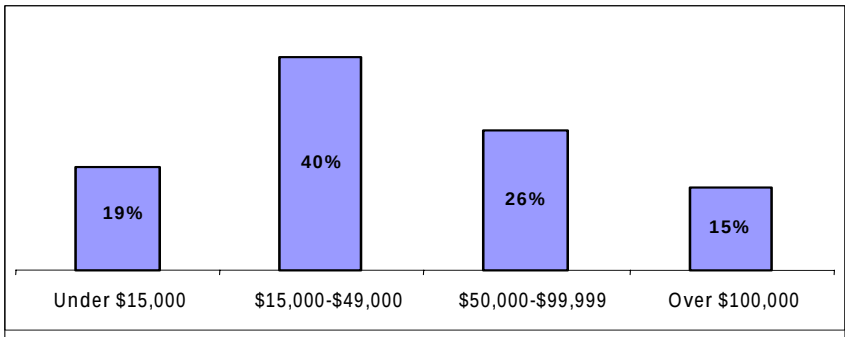
Income Resources

The number of older Californians at both ends of the income scale is growing, creating two very different groups: persons with annual incomes over $50,000 (41 percent) and persons with incomes below $15,000 (19 percent), with a diverse middle class in between (See Figure 4).

Older Californians in higher income brackets are predominantly white, a trend that will accelerate as the white wealthy baby boomers age. Those with incomes under $15,000 are, for the most part, elders of color—a trend that will also accelerate as "boomers of color" age. Over 50 percent of older adult immigrants are within 200 percent of the poverty level, compared to 33 percent of native born older Californians.

Older Californians at the middle-income level are more evenly distributed along ethnic lines, although middle-income elders of color tend to have fewer assets and are more likely to slide into poverty than their white counterparts.

Figure 4
Annual Income for Individuals Age 55 and Over as a Percentage of Total Population (1999)

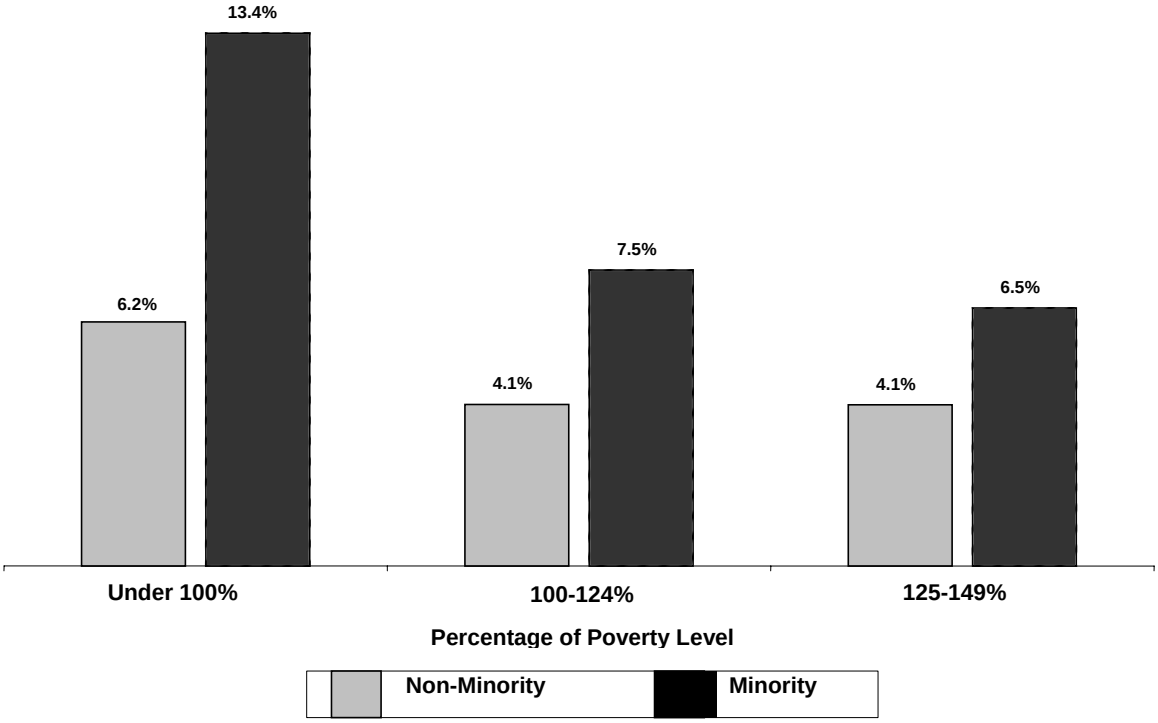


The highest proportion of older adults with income below 200 percent of the Federal Poverty Level (FPL) are in Imperial County, followed by several counties in Northern California and the Central Valley, where about two-fifths of older adults are low income. Eight percent of the population age 65 and over have income below the FPL and another 21 percent have incomes between 100-199 percent of FPL. This group also need to be included in this discussion since they have incomes too high to make them eligible for many public assistance programs, yet often fail to have sufficient resources to meet their most basic needs. [2]

For very poor older Californians, Supplemental Security Income (SSI) is the primary source of their income. SSI provides a minimum guaranteed monthly income for all qualified individuals who are age 65 and over or blind or disabled. The State of California supplements the federal benefit substantially through the State Supplementary Program (SSP). In 2000, the combined SSI/SSP annual benefit was

$9,000 for a single older individual and $14,748 for an older couple living independently. However, SSI recipients cannot earn income that exceeds their SSI benefit without reducing their payment amount, and accumulated assets must fall below certain limits. So many poor older adults are not eligible for SSI because their assets exceed the maximum allowed. Many others do not apply for the benefit because they do not know they are eligible or do not want to be on a public assistance program.

Figure 5
Poverty Level Among Californians Age 60 in 2000, by Racial Status



In 2000, 100 percent of the federal poverty level for a single individual was $8,350 and 150 percent was $12,525 annually. Twice as many Minority elders (13.4 percent) were below 100 percent of poverty compared to White elders (6.2%) (see Figure 5). Among elders in various racial groups, approximately 11 percent of Asians, 15 percent of Latinos, 16 percent of African Americans, and 16 percent of Native Americans were below the poverty level. For SSI/SSP beneficiaries, these payments raise their income level to between 100-124 percent of the federal poverty level Approximately 63 percent of White, 54 percent of Asian, 44 percent of African American, 41 percent of Native American, and 37 percent of Latino elders had incomes over 300 percent of the poverty level.

Health Status

The dramatic gains in life expectancy that occurred during the 20th century were primarily due to advances in sanitation, medical care, and the use of preventive health services. These factors also account for a major shift over the past century in the

leading causes of death—from infectious diseases and acute illnesses to chronic diseases and degenerative illnesses.

In 2000, the top three leading causes of death for all ages were heart disease (30% of all deaths), cancer (23%) and stroke (7%). These three leading causes of death account for 60 percent of all deaths among older adults. [11]

However, many of these leading causes of death can be prevented. Although the risk of disease and disability increase with age, poor health is not an inevitable consequence of aging. Three behaviors—smoking, poor diet, and physical inactivity—were the actual causes of almost 35 percent of U.S. deaths in 2000. [12]

These behaviors often lead to the chronic disease killers: heart disease, cancer, stroke, and diabetes. Adopting healthier behaviors (regular physical activity, a healthy diet, and smoke free lifestyle) and getting regular health screenings (e.g., mammograms, colonoscopies, cholesterol, bone density, etc.) can dramatically reduce the risk for most chronic diseases.

Healthy People 2000 set targeted goals for improving the health of all Americans. *The National Report Card on Healthy Aging* reports on 15 key indicators included in the *Healthy People 2000* report that present a comprehensive picture of the health of older adults (age 65 and over).[13] This report card shows the most current data for each indicator and assigns a "pass" or "fail" based on the *Healthy People 2000* targets (see Table 7). California's ranking among other states is also indicated.

Table 7
Healthy Aging—How California Scores on a National Report Card

Health Indicator	Year data collected	Data	Rank Among States	Grade
Health Status				
1. Physically unhealthy days (mean number of days in past month)	2001	5.1 days	12	n/a
2. Frequent mental distress (%)	2000-2001	5.9 %	17	n/a
3. Oral health: complete tooth loss (%)	2002	13.2%	1	Pass
4. Disability (%)	2001	29.7%	17	n/a
Health Behaviors				
5. No leisure time physical activity in past month (%)	2002	25.8%	6	Fail
6. Eating 5+ fruits & vegetables daily (%)	2002	35.6%	10	Fail
7. Obesity (%)	2002	19.1%	22	n/a
8. Current Smoking (%)	2002	9.9%	24	Pass
Preventive Care & Screening				
9. Flu vaccine in past year (%)	2002	71.5%	15	Pass

Health Indicator	Year data collected	Data	Rank Among States	Grade
10. Ever had Pneumonia Shot (5)	2002	66.7%	10	Pass
11. Mammogram in past 2 years (%)	2002	80.7%	12	Pass
12. Ever had Sigmoidoscopy/ Colonoscopy (%)	2002	62.2%	13	Pass
13. Up-to-date on select preventive services—men (%)	2002	43.9%	8	n/a
14. Up-to-date on select preventive services—women (%)	2002	38.5%	11	n/a
15. Cholesterol checked in past 5 years (%)	2001	82.6%	38	Pass

Comparatively, California's overall scores for Preventive Care and Screenings were "passing" with 80 percent of older women having mammograms within the past two years and 82 percent of older adults having a cholesterol check in the past 5 years. However, California failed in two Health Behavior measures: 25 percent of older adults indicated that they had engaged in no leisure time physical activity in the past month and only 36 percent eat five fruits and vegetables daily.

If California's older adult score card were analyzed by race and ethnicity and by county, other trends would emerge. For example, older African Americans (47 percent) and Latinos (45 percent) did not receive a flu vaccination in the past year and Riverside/Imperial and Napa counties had the lowest vaccination rates. African American older adults have a significantly higher smoking rate (14 percent) versus 8 percent for other racial and ethnic groups and Shasta, Napa and Sacramento counties had the highest rates of older smokers (over 12 percent compared to 9.9 percent statewide). While about 38 percent of older Californians have not had colon cancer screening, 57 percent of older Asian Americans and 59 percent of limited English speaking elders have not had this preventive screening test. [2]

Older Latinos and those with limited English abilities have the worst health profiles compared to statewide averages. It should be noted that a partial overlap exists between these two groups. About 40 percent of older Latinos have limited English proficiency and about 45 percent of the older limited English speaking group is Latino.

The National Report Card on Healthy Aging provides good indicators as to where additional attention needs to be focused to improve the health of older Californians and is reflected in CDA's priorities for 2005-2009, which are presented in Section V.

Section III Developing Coordinated Service Systems

> *"At the local level, Area Agencies, hospitals and other community organizations are looking to systems development as a way of making it easier for service providers, older people and their families to navigate an increasingly complex maze of social and health care services. Leaders at all three levels* (federal, State and local) *believe systems development can help improve the effectiveness and efficiency of services delivered to older persons in their communities."*
>
> Developing Community Based Systems of Care[14]

Local Level: Area Agencies on Aging

At the federal level, the OAA provides the legislative context for Area Agencies to carry out their systems development role. Systems development is defined as the set of activities and processes used by the Area Agency and other organizations to envision, plan, manage, coordinate, integrate, evaluate, refine and improve the quality of a community's constellation of services. Systems development seeks to address four major problems associated with the delivering community services. These problems include:

- Difficulty in accessing or using services, especially if multiple services are required;
- Fragmentation of services;
- Duplication of services; and
- Gaps in services.

Systems development does not take place in a vacuum. Rather, it is created within the context of laws, regulations, organizational arrangements, and expectations created and shaped at federal, state and local levels. Four sections of the federal OAA spell out how Area Agencies are to carry out their systems development role:

1. Part A of Title III, Grants for State and Community Programs on Aging, identifies the ultimate goal of Area Agencies' systems development efforts to be the opportunity for older persons to remain independent in their homes and community as long as possible;
2. The definitions section of Title III Part A outlines the purpose of a comprehensive and coordinated system, making it clear that systems development efforts are to extend beyond Title III funded services to include <u>all</u> supportive services provided by both public and private entities. This section also emphasizes the need for efficiency in the organization of the service delivery system;
3. The Rules and Regulations Subpart C, "Area Agency Responsibilities" set forth the mission of the Area Agencies and mandate them to carry out a proactive

leadership role in systems development in each community in the planning and service area (PSA); and

4. Subpart C also describes the characteristics of the comprehensive and coordinated system, processes to be used and criteria for evaluating the performance of the system.

Barriers to systems development are numerous. Programs are often categorical in terms of their financing, eligibility criteria and administrative requirements, making coordination quiet challenging. Agencies can have different allegiances and values, which guide their approaches to serving clients. In short, basic differences in operations and philosophy may make organizations feel threatened or challenged by collaborative efforts and may make it difficult to create a shared "vision" of what a system of care should accomplish.

AAAs often do not have the authority to "require" other agencies or organizations to participate in their systems development efforts. Other organizations in the system of care may not even be aware of the Area Agency's systems development role.

Even if local agencies do conceptually have a shared vision, systems development requires a commitment of time and resources from all parties involved. In times of budget and staffing reductions, allocating resources for these efforts can become even more challenging. Although, with strong leadership, times of fiscal austerity can also create the impetus for collaboration and sharing of resources to help compensate for reduced funding to some degree.

> "...without a vision or clear sense of direction, organizations are often unable to assess the impact of their efforts and some become frustrated when systems development appears to be synonymous with means, such as development of an assessment tool, rather than an ends, such as improving opportunities for frail elders to remain in the community."
>
> ---Developing Community Based Systems of Care[14]

Finally, systems development is an ongoing process that is never complete. Simply having services, structures and processes in place does not guarantee that a system will work smoothly. Dedicated leadership, careful listening and observation, and active hands-on management are needed to help ensure that the system continues to be responsive to the needs of older persons and their families.

While the obstacles noted above are not insurmountable, they do underscore the challenges involved in the Area Agency's system development mandate and the need for careful planning efforts.

State Level: California Department of Aging

Just as the OAA provides the overarching mandate for AAAs to become actively engaged in systems development efforts, state-level policies and structures also define the Area Agency's systems development role. Particularly important are policies, which determine legislative mandates for systems development. The California Legislature has explicitly charged CDA with the responsibility to develop the system of care and sanctioned interagency task forces, committees and similar structures as vehicles for coordinating the efforts of state-level departments that serve older persons. The existence of these structures, as well as the expectations they create, help facilitate systems development efforts at the local level.

The OAA and the OCA make it clear that the CDA is expected to play an important role in helping Area Agencies and their local communities develop systems of care. As with AAAs, CDA often does not have the authority to "require" other agencies or organizations to participate in systems development efforts. Needed services may not be under CDA's or the local AAA's administrative or budgetary authority.

CDA assists AAAs and communities by:

1. Working with other State departments and agencies, Area Agencies and other local entities to define roles and responsibilities at both the State and local levels.;
2. Providing Area Plan guidance that encourages and supports systems development;
3. Working to remove State-level barriers. CDA works with sister agencies to resolve implementation issues;
4. Developing common program standards including service unit definitions and reporting requirements;
5. Fostering the development and implementation of common intake, screening and assessment instruments;
6. Actively supporting local efforts;
7. Helping to improve access to information, resources and services;
8. Providing training and technical assistance to individuals and organizations at the local level as needed;
9. Sharing promising practices; and
10. Refining data collection and reporting to improve the information available to decision makers in developing policies that affect older adults.

Section IV Key Issues and Promising Practices

This 2005-2009 CDA State Plan was developed with input gathered from local planning processes. The Area Agencies follow a planning process for coordinated systems development as area plans are developed. The Department replicated this process to the greatest extent possible to reflect and support local and State level efforts. Area Agency input was collected through a written survey as the agencies developed their plans for the 2005-2009 planning cycle. This survey asked AAAs to identify:

1. Principal resources used for planning and community-based services (CBS) systems development;
2. Principal constraints affecting planning and CBS systems development;
3. Examples of demonstrated leadership in developing CBS systems;
4. Tools used to conduct needs assessment;
5. Highest current service needs;
6. Projected AAA priorities for the 2005-2009 planning period (including how the AAA is planning to meet the challenges of the state's increasingly diverse population & the leading edge of the Baby Boomers becoming eligible for OAA services);
7. Top areas of current unmet need; and
8. Promising practices in responding to current or developing service needs.

Twenty-six of California's thirty-three AAAs responded to this survey, providing a significant amount of the information that was helpful in preparing this report, in identifying promising practices that can be more broadly disseminated, and in helping the Department understand organizational and resource issues that AAAs in different parts of the state are experiencing.

Four critical issues emerged in terms of current service needs, unmet needs, and projected needs:

- Outreach and Information (Access to needed services)
- Maintaining and Improving Health
- Housing
- Transportation

Outreach and Information

As California prepares for a rapid growth in its aging population, the State must identify, test and implement effective means of providing outreach and information to a more diverse and rapidly growing number of older adults, family caregivers, and multidisciplinary professionals (as well as young people exploring career options) seeking:

- Information on healthy aging and preventive health options;
- Help in understanding and finding the full range of in-home and community options available to support continued independence and quality of life; and
- Training and professional growth opportunities for those serving older and disabled adults.

AAA Findings Statewide, AAA needs assessments indicated that older adults do not know how to access available services and that information on what services exist and how to access them is one of the most pressing needs.

Promising Practices to Expand Outreach and Information *Activities some AAAs have undertaken to increase outreach and education in their community include:*

- Sponsoring increased numbers of health fairs, healthy aging summits, and senior festivals in various locations including shopping malls;
- Using AAA InfoVans to facilitate "Making the Link," a program of the National Association of Area Agencies on Aging to increase awareness among physicians and their office staff about the essential role of the informal caregiver, the impact of caregiving, and the availability of caregiver support services. These InfoVans take outreach and education on the road, particularly to reach geographically remote and traditionally underserved populations;
- Co-sponsoring educational workshops on various aspects of Elder Abuse Prevention;
- Initiating or partnering in efforts to create a "single entry point" to help individuals access all appropriate services with less "run around" (many AAAs are involved in these types of activities);
- Merging county agencies to facilitate development of "single entry point;"
- Implementing "single entry point" call centers and preparing for roll out of "211" toll free telephone information number (similar to "411" but can ask for the number of a generic type of social or health services without knowing the exact name of the agency providing it);
- Training I&A staff to initially distinguish whether they are talking with an older adult or the caregiver of an older adult, and then ask key questions to determine whether the caller has concerns related to his or her role as a caregiver in addition to services they may be seeking for an older adult family member;
- Creating or expanding agency web site to increase access to information 24/7;
- Implementing an Aging and Disability Resource Center, under an AoA and CMS grant, to increase outreach, improve information and assistance, and provide better access to needed in-home and home and community-based services;
- Establishing many more activities targeting diverse cultural and ethnic groups, which in some areas included creating neighborhood partnerships with African American, Latino, Asian Pacific Islander and lesbian, gay, bisexual and transgender groups;
- Increasing Health Insurance Counseling and Advocacy Program (HICAP) education and counseling sessions to respond to increased demand related to the prescription drug provisions in the Medicare Modernization Act; and
- Co-locating a public location at the county resource center that provides aging, caregiver and disability services (branch library users will automatically learn where to turn for assistance when they have aging or disability questions when they visit that location).

Maintaining and Improving Health

"In recent decades, there has been a growing appreciation for the fact that older age, while a time of greater risk for declines in health and functioning, need not inevitably be associated with such negative outcomes. Indeed, there has been an increased awareness that considerable numbers of older adults continue to enjoy relatively high levels of physical and cognitive functioning and remain actively engaged in various life pursuits well into their 70s and 80s, and even 90s. Despite considerable and needed attention that is devoted to health and functional problems most commonly seen in older age groups, aging is not uniformly associated with significant disease and disability.

Health promotion activities consisting of exercise, nutritional guidance and regular preventive physician visits will need to be greatly expanded if they are to have any meaningful and long term positive impacts upon both health maintenance and cost containment of health care…Policymakers will need to consider ways to invest in disease prevention as a way to promote wellness in our older population."

--Teresa Seman. *Optimizing Trajectories of Aging in the 21st Century*. California Policy Research Center Brief, No. 6, May 2001, excerpted in *SB 910 Strategic Plan for an Aging California Population*, 2003.

AAA Findings

- Many older and disabled adults cannot afford needed prescription drugs;
- Increased health insurance premiums, elimination/reduction of retiree health plan benefits, loss of managed care plans, limited or no dental coverage, and increased Medicare premiums and co-payments are contributing to a health care crisis;
- More education is needed so older adults understand what services Medicare covers and available options when Medicare doesn't cover the service;
- Congregate nutrition program needs to be redesigned to better meet changing needs;
- Respite care was identified as important to older adults and their families in preventing the health problems associated with caregiver responsibilities. One AAA telephone survey found that almost a quarter of respondents needed respite assistance in caring for a spouse, parent, grandchild or other relative;
- Waiting lists for home delivered meals, respite, Linkages and transportation services persist in certain areas;
- More education on medication management for older and disabled adults is needed; and
- Additional help with household chores is needed when performing these tasks becomes too difficult.

Promising Practices to Improve and Maintain Health *Activities some AAAs have undertaken to increase health access, wellness, and chronic disease self management in their communities include:*

- Securing grant funding to implement a Medicare Access to Benefits program;
- Establishing an emergency cell phone program to ensure that older and disabled adults with mobility limitations can make a “911” call in an emergency;
- Increasing Senior Health Fairs to make flu shots available during vaccination shortage;
- Developing an affordable drop-in social respite program that relied on community volunteers and local churches or senior centers for staffing and administrative support;
- Organizing a cooking class for male caregivers who are not accustomed to cooking that also provided them with a break from their caregiving responsibilities and peer support;
- Implementing a specialized hospice service program;
- Developing a supplemental Meals-on-Wheels program to provide needed meals to individuals age 18-59, who are not eligible for OAA funded meals because of their age;
- Expanding public awareness of senior substance abuse issues;
- Supporting a medication management program that uses computerized medication dispensers in the homes of frail older adults at risk of medication errors;
- Partnering in the development of a senior care center that will provide geriatric assessments for older adults who do not have a primary care physician or have chronic or complex health conditions;
- Initiating a house calls program in collaboration with community mental health agency to conduct a chronic disease prevention and management program with older adults in low income housing;
- Participating and funding older adult fall prevention activities (several AAAs have been actively involved in these efforts);
- Implementing caregiver registries and conducting recruitment and educational activities to increase the number of In-Home Supportive Services (IHSS) workers, who serve older persons; and
- Providing on-going family caregiver support groups, educational activities, and respite services.

> “Ultimately, the standard for health care will not relate only to physical health, but the holistic health of the person—including physical and mental health and wellness.”
>
> --*Planning for an Aging California Population: Preparing for the “Aging Baby Boomers.”* California Assembly Aging and Long Term Care Committee, May 2004, pg. 3.

Housing Issues

> "A significant percentage of older adults in California face serious housing related problems. Many people over age 65, burdened by high housing costs and living on fixed incomes, are in need of affordable housing. This is particularly true for those who live alone and are low income, and urgent for many women and minority group members. Older Californians need adequate housing; the substandard dwellings many live in are unsafe and in serious need of repair. Many housing situations do not provide the adaptability and accessibility older adults require; simple home modification and more complex adaptations can make physical space supportive and safe, easing the ability to "age in place." Institutionalized care can be delayed, even avoided, as housing options become more appropriate by providing or linking with supportive services."
>
> --John Pynoos et al. *Housing for Older Californians*. California Policy Research Center Brief, No. 6, May 2001.

AAA Findings

- Skyrocketing real estate prices continue to limit housing options, increasing the need for and pressure on existing moderate and low income housing options. This results in increased waiting lists for low-income housing, limited community care facilities, increased rental rates, and increased homeless seniors. Middle-income older adults are also squeezed in this high cost housing market;

- Older and disabled adults often face difficulty in finding affordable housing coupled with difficulty in obtaining needed services and/or amenities due to functional limitations;

- Help with yard work and making home modifications, such as adding a wheelchair ramp and emergency response buttons/cell phones are also needed to help older persons remain independent in their homes; and

- Some older and disabled adults at risk of losing their independent housing need chronic disease care management, health education and other supports that would make it possible for them to remain in their home and community.

Promising Practices to Address Housing Issues Housing and transportation issues are interrelated because they are land use issues. Some AAAs act as clearinghouse to help identify available housing and/or work in partnership with local housing authorities to assist older or disabled adults in finding affordable and accessible housing. Specific a*ctivities some AAAs have undertaken to address housing issues in their community include:*

- Collaborating with local housing authorities in presenting forums on affordable senior housing that has drawn the attention of local and state policymakers; and

- Strengthening home modification and repair programs through the use of Title III-E funding and new volunteer action coalitions.

Transportation Issues

> "Mobility is critical to the well-being of California's elderly…To life full lives and avoid social isolation, people must be able to access friends and relatives, health care services, shopping opportunities, and social and recreational activities. Older Californians are the most automobile dependent group in our society, making well over 90 percent of their trips in automobiles, either as drivers or as passengers. Over time, the elderly are becoming ever more automobile oriented, and an increasing proportion of them live in "mega-suburb" communities, making it difficult to reach their destination by transit and walking. Given that transportation needs are directly interrelated to land use planning, policymakers will be forced to develop alternative transportation services, driver safety education, "walkable" communities, and better access to public transportation."
>
> --Martin Wachs. *Mobility for California's Aging Population*. California Policy Research Center Brief, No. 6, May 2001, excerpted in *SB 910 Strategic Plan for an Aging California Population*, 2003.

AAA Findings

- The need for additional transportation services was clearly identified as a needed service and an area where there is significant unmet need for assistance;

- Expanded public transportation routes and systems, including light rail and accessible buses, must be part of the answer. But improved and expanded door-to-door transportation services (e.g., ParaTransit, Dial-a-Ride, etc.) are also needed to meet the needs of the disabled who cannot safely use or navigate public transportation systems; and

- In rural areas, the inability to drive becomes an even greater challenge since the lack of population density results in less affordable public transportation and more costly door-to-door transportation.

Promising Practices to Address Transportation Issues

- Developing volunteer based transportation programs using county-owned vehicles and volunteer drivers to take older and disabled adults to grocery and drug stores, meal programs, medical appointments, etc.;
- Implementing a special Sunday transportation program in areas where ParaTransit does not operate to permit older and disabled adults to attend religious services, shop or visit family and friends;
- Cosponsoring educational sessions to help older and disabled adults learn how to use public transportation, through demonstration and instruction;
- Expanding transportation assistance (errand and escort) programs; and

- Supporting legal action on behalf of ParaTransit riders when application and screening criteria were proposed that would have potentially reduced the number of funded rides in half (The transit authority is now revisiting proposed changes).

Section V Past Accomplishments and Future Priorities

Building on the issues identified in the 2003 *Strategic Plan for an Aging California* and the issues raised in Section IV of this Plan, CDA proposes to respond to the needs, challenges, and opportunities presented by California's growing population of older adults by focusing its activities and resources during 2005-2009 in seven key areas:

- Ensure Access to Services through Effective Education and Outreach;
- Promote Optimal Physical, Mental and Social Well-Being among Older Adults and their Informal Caregivers;
- Protect the Quality of Life and Rights of Elders through Education, Legal Services, and Improved Coordination with Law Enforcement;
- Strengthen the Quality and Accountability in CDA Programs;
- Promote Volunteerism to Expand Services and Provide Opportunities to Serve the Public;
- Use Existing and Emerging Technology to Improve Service Delivery, Program Management and Accountability, and Policy Development; and
- Improve CDA Business Practices to Support Policy and Programmatic Goals.

As noted in Section III, the Older Americans Act broadly charges State Units on Aging and AAAs to advocate on behalf of older adults for services they may need, even if the majority of the funding for those services or programs are not under the administrative or funding authority of the State Unit or AAAs. Examples include physical health, mental health, housing and transportation services.

While CDA will advocate for these much needed services, in this 2005-2009 State Plan, the Department has established objectives and key action steps only in areas where the Department has the programmatic and budgetary resource authority needed to manage the implement of these activities.

Several of these objectives are interconnected. Section V will discuss each major objective, very briefly highlight accomplishments in these areas over the past four years, and present California's priorities for the coming four years.

Ensure Access to Services through Effective Education and Outreach

Major Accomplishments (2000-2004)

- InfoVans are taking Information and Assistance "on the road," to older individuals and their caregivers throughout the state;

- Increased Internet information is now available on aging, disability, and caregiving issues and service options; **www.networkofcare.org**, one such website, has received national recognition; and

- Attention is being given to addressing the growing diversity of California's older adults and their informal caregivers, through needs assessments, specialized

outreach and programming for older adults who are African-American, Latino, Chinese, Hmong, Vietnamese, Korean and other Asian Pacific Islanders, Russian and other ethnic groups, as well as gay and lesbian elders.

Current and Future Concerns

- More effective outreach and information and assistance infrastructure must be developed to reach a rapidly growing and more diverse population;
- The process individuals go through for service screening, assessment and intake must be streamlined to so that clients don't have to "jump through so many hoops," and services are received in a timely manner;
- Responding to the needs of a very diverse older adult population will require additional expertise and resources; and
- Federal grants help test innovations and reforms but they do not sustain or expand these efforts for the long term.

Priorities for 2005-2009

Objective 1 Improve the Information and Assistance (I&A) system statewide to ensure that older adults, family caregivers, and service providers have easy access to needed information and services.

Background

Traditionally, older persons and adults with disabilities turned to family, friends, doctors and clergy when in need of advice. Today, older persons and their caregivers face a complicated array of choices and decisions about their health care, pensions, insurance, housing, transportation, financial management and long-term care needs. Depending on individual circumstances, needed assistance and support can be as simple as factual information or involve advocacy and interventions on behalf of individuals who are frail and vulnerable. Timely and comprehensive assessment, follow-up and efficient access to needed information and services is essential to sustain individuals in their own homes and communities.

California is home to the nation's largest number of older adults and must address diversity issues on a scale unlike any other state. California is both urban and suburban and yet is a very rural state as well. In the coming five years, we must find effective ways to better reach the state's culturally diverse population needing of aging and disability services. These approaches must be broadly applicable and cost effective, given the size of the population potentially needing this assistance.

CDA currently is implementing a federal Aging and Disability Resource Center grant, exploring new strategies for expanding I&A services, providing outreach to diverse populations, and streamlining the transition from I&A to program referral, assessment and intake. This grant will provide the state with valuable guidance in developing viable approaches that can work in this State.

CDA is also implementing an AoA Alzheimer's Demonstration grant, focused on increasing family caregiver education on Alzheimer's disease and related disorders and linkage to needed services among Chinese, Korean and Vietnamese families in Northern and Southern California. This program will also increase the cultural competency of mainstream health, social, and aging service providers serving these families. This grant will also provide valuable information to the State in addressing the I&A needs of diverse and often hard to reach populations.

Key Actions

- ✓ Incorporate *Visions 2010,* the *Alliance of Information and Referral Systems (AIRS) Standards,* and the related self-assessment guide into the Area Plan contract for Title IIIB programs;

    - Ensure that all AAAs receive direction on AIRS Standards and that CDA includes these Standards in the 2005-2006 AAA I&A service monitoring process; and

    - Work with AAAs to insure that I&A staff are qualified and experienced;

- ✓ Improve visibility of and communications among I&A providers statewide by creating an I&A Users Group, a directory of all I&A sites on CDA's website, and a link for information sharing on CDA's website for AAA's I&A coordinators and their providers;

- ✓ Expand State level involvement in the development of the 211 central information telephone system to ensure that the needs of older adult, persons with disabilities and caregivers are adequately addressed;

- ✓ If the Aging and Disability Resource Center grant outcomes are successful, encourage greater co-location of frequently needed services (even if the services are funding by different agencies); and

- ✓ Facilitate diversity training for CDA staff and external stakeholders to promote cultural competence and sensitivity in providing services so that ethnic and cultural differences are not a barrier to accessing services.

Objective 2 Improve the efficiency of care management services provided to older adults.

Background

Care coordination assists individuals to remain as independent as possible through the use of home and community-based services. Individuals may need several services such as medical care, financial assistance, minor home modifications, and personal care services. Care managers assess client's needs and preferences, develop a responsive care plan, authorize and monitor services, evaluate progress, and revise the care plan as needs change.

In the network of services for older persons, care coordination is provided by the Multipurpose Senior Services Program (MSSP), Linkages (which also serves younger adults with disabilities) and Older Americans Act Title III-B and Title III-E programs. Without the services provided by care managers, many older adults, particularly those with substantial functional limitations, would not be able to remain in their own home and community, and their informal caregivers would not be able to maintain the level of support needed to keep their family member from being institutionalized.
While standards are in place for the MSSP program, standards need to be developed for Linkages and Title III care management programs and coordination among the three programs could be strengthened.

Key Actions

- ✓ Collaborate with stakeholders (MSSP, Linkages, AAAs, etc.) to promote a client centered and strength-based approach and a commitment to quality services and continuous improvement;
- ✓ Coordinate with stakeholders to encourage a coordinated or single entry access to services at the local level;
- ✓ Develop standard comprehensive assessment and care planning tools with consultation from stakeholders consistent with federal initiatives;
- ✓ Develop polices and protocols that foster effective and timely care coordination with other providers serving the client;
- ✓ Identify, evaluate, and encourage the use of electronic systems for sharing information with partners in serving the client;
- ✓ Develop and monitor to quality standards for care management services;
- ✓ Institute continuous review and quality assurance, including cost effectiveness and utilization review;
- ✓ Develop standards for outcome measurement and provide for consistent training and support; and
- ✓ Collaborate with AAAs to ensure efficiency of care management services and coordination with other care management and caregiver programs. Include Linkages, other care management and caregiver stakeholders in the development of guidelines and standards for the OAA Title IIIB Case Management Services Program and OAA Title III-E Program.

Objective 3 Restructure the Health Insurance Counseling and Advocacy Program (HICAP) to Respond to its Changing Role and the Increased Complexity of the Medicare Program.

Background

The Medicare Modernization Act (MMA) of 2003 has greatly expanded HICAP's responsibilities. The federal Center for Medicare and Medicaid (CMS) is turning to HICAP as a key partner in providing objective, fact-based counseling and information to Medicare beneficiaries, the dual eligible population (those eligible for both Medicare and Medi-Cal), and the hardest-to-reach and low-income populations. Historically, HICAPs have primarily referred persons with Medi-Cal issues to the Department of Health Services (DHS) for resolution. Given HICAP's additional role in targeting services to these groups and California's growing diversity, this expanded role demonstrates a major shift in responsibility and presents complex challenges.

The MMA also includes a new Medicare prescription drug benefit. This benefit has complex provisions and will be particularly challenging for the dual eligible population since they will lose their Medi-Cal drug coverage effective December 31, 2005, and be automatically transitioned to a Medicare approved private drug plan. This significant change to the Medicare program will also add to the current complexity of HICAP education, counseling and advocacy efforts.

Action Steps

- ✓ Evaluate the capabilities of the existing cadre of HICAP volunteers and make recommendations on infrastructure changes to meet MMA demands;
- ✓ Implement new performance measures;
- ✓ Develop a strategic plan for implementing infrastructure changes;
- ✓ Coordinate with all affected parties to ensure a smooth and integrated approach to implementing the new Medicare prescription drug benefit and infrastructure changes; and
- ✓ Identify and act on needed policy changes that become apparent in implementing the MMA.

Objective 4 Increase the coordination between family caregiver supportive services and home and community-based supportive services so that all of a family's needs are being identified and responded to in the most comprehensive manner possible.

Background

The Family Caregiver Support Program (FCSP) is a relatively new OAA program. CDA is seeking to encourage AAAs to use this funding in the most effective manner possible to provide comprehensive support to families in need. For example, when an older adult (or family member) contacts his or her AAA for care management or homemaker services, the presence of family caregivers should be noted during the assessment and

their need for support should also be identified. Assessment and referral of family members caring for participants in the MSSP waiver to appropriate caregiver supports should also be encouraged. This increased level of coordination should help families in sustaining their caregiving role, which, in turn, may delay or avoid Medi-Cal costs to the State and federal government. Individuals can no longer be supported solely with informal or private resources must spend down their assets until they are Medi-Cal eligible.

California must also promote outreach strategies that are culturally responsive to the needs and preferences of the growing diversity of the state's informal caregivers, particularly those who are in greatest social and economic need.

Key Actions

- ✓ Monitor the AAAs to ensure good coordination between their FCSP services with the other services being provided through the OAA, the OCA and the MSSP waiver program;
- ✓ Monitor the AAAs to ensure good coordination between their FCSP services and those provided by the Family Caregiver Resource Centers, overseen by the Department of Mental Health; and
- ✓ Identify and disseminate promising practices in reaching and serving often hard to reach populations, who may not readily identify as "family caregivers," may not speak English, may be low income and may reside in rural, isolated areas of the State.

Objective 5 Expand available Older Americans Act services by developing and implementing a cost-sharing policy for these programs, unless prohibited by federal law.

Background

The OAA now requires that all participants be given the opportunity to contribute toward the cost of the services they receive. The purpose of cost sharing is to expand the availability of these services by soliciting contributions from those who receive services, based on their ability to pay. Revenues collected from service recipients will be retained by local providers and used to increase services.

Cost-sharing is not allowed for Information & Assistance, Outreach, Case Management, Ombudsman, Elder Abuse Prevention, Legal Assistance or Congregate and Home-Delivered Meal programs.

Action Steps

- ✓ Solicit views of older individuals, providers, and other stakeholders on implementation of cost-sharing in the State;
- ✓ Establish a sliding scale, based solely on individual income and the cost of delivering services;

- ✓ Develop plans that are designed to ensure that the participation of low-income older individuals receiving services will not decrease with the implementation of cost-sharing;
- ✓ Develop simple written materials in various languages to communicate the cost sharing provisions; and
- ✓ Develop a process to allow for AAAs to request a waiver from the State's cost-sharing policies.

Promote Optimal Physical, Mental and Social Well-Being among Older Adults and Their Informal Caregivers

Major Accomplishments (2000-2004)

- Implemented *Senior Farmers Market Program*, to educate low income older adults on the importance of fruits and vegetables in their diet and to increase their access to fresh produce. Almost 200,000 older adults received coupon booklets totaling over $4 million to purchase fresh produce at these markets between 2001-04;

- Implemented the FCSP, which in 2001-04 provided 407,000 units of outreach, 1.5 million hours of respite, and 139,000 hours of assessment, care management, and counseling;

- Collaborated in fall prevention and strength training programs serving at-risk older adults, through a coalition funded by the Archstone Foundation, that includes many AAAs, hospitals, academic institutions, and health agencies; and

- Developed a stronger working relationship between the State Departments of Aging and Rehabilitation that mirrors the growing regional collaborations between the AAAs and the Independent Living Centers.

Current and Future Concerns

- ✔ Significant health disparities exist for ethnic older adults;
- ✔ Good health in later years is closely related to educational achievement, income status, and access to health care earlier in life. The gap between the "have's" and the "have not's" in California's population is growing;
- ✔ With a rapidly aging society, effective treatment for chronic conditions has become more critical given its significant impact on quality of life and health care expenditures;
- ✔ Many older and disabled adults have little or no insurance coverage that pays for needed prescription drugs, dental, or mental health services; and
- ✔ Health advances and health care coverage is becoming more and more complicated while the health care literacy is not increasing overall.

Priorities for 2005-2009

Objective 6. Increase health promotion and disease prevention services for older adults.

Background

Increasingly, CDA has sought to incorporate health promotion and disease prevention education throughout its programs given the benefit of these activities in increased quality of life and reduced health care costs. Although funding resources have been reduced, opportunities still exist through partnerships with other organizations.

Title III-D of the Older Americans Act provides a small amount of funding for a wide range of health promotion and disease prevention activities, including exercise programs, health screenings, blood pressure monitoring, nutrition counseling and education for individuals and primary caregivers. Intergenerational approaches can also be funded. Programs focused on to chronic conditions (including osteoporosis, arthritis, and cardiovascular disease), preventing and reducing the effects of alcohol and substance abuse, smoking cessation, weight loss and stress management can be supported with Title III-D funds. However, to date, CDA has provided minimal guidelines to AAAs concerning the use of Title III-D funds.

Key Actions

- ✓ Develop and provide additional guidance to AAAs on the broad range of activities that can be funded through Title III-D;
- ✓ Create opportunities to share promising practices in health promotion and disease prevention with AAAs and other CDA stakeholders; and
- ✓ Encourage AAAs and other CDA stakeholders to participate in health promotion efforts underway, such as the federal AoA "YouCan" campaign.

Objective 7 Identify opportunities to increase the effectiveness of the Elderly Nutrition Program and implement appropriate improvements.

Background

The California Elderly Nutrition Program (ENP) serves approximately 200,000 seniors, providing 21 million meals annually at senior centers and through the home-delivered meal program. It is CDA's largest program. However, flat funding for the program over the past 10 years has resulted in fewer meals being delivered (an approximate 5% decrease annually) because of the increased costs of food, gasoline, salaries, etc. There is also a sense that tomorrow's older adults, the leading edge of the Baby Boomers, will not be as interested in congregate meal programs as they exist today. Strategies must be developed to prevent a further decline in the congregate and home-delivered meals served statewide.

Key Actions

- ✓ Analyze factors that have caused the decline in home delivered meals over the past five years;
- ✓ Identify alternatives to maintain and/or increase in-home meal availability;

- ✓ Review participation trends in the congregate meal programs over the past five years by age cohort to determine whether fewer 60-70 year olds are attending these programs; and
- ✓ Develop recommendations on program options for congregate meal programs in the future based on current participation patterns and projections for use by the first cohort of Baby Boomers.

Objective 8 Improve Oral Health Care for Residents in Long-Term Care Facilities.

Background

Dental care is problematic for many residents in LTC facilities as noted in the Surgeon General's *Oral Health Care in America* report (2000). Many elders lose their dental insurance when they retire. Medi-Cal provides coverage to low income individuals, but Medicare provides no coverage at all. Residents with dementia may be unwilling or unable to brush their teeth. Oral health care problems can limit the quality of life for many residents and have negative consequences for their overall physical health as well.

Key Actions

- ✓ Provide training for Ombudsman, LTC facility staff, residents, and families to increase awareness of the importance of good oral health care;
- ✓ Identify and disseminate effective information on oral care techniques that direct care staff can use when residents, particularly those with cognitive impairments, are resistant to brushing their teeth and performing other important routine oral health practices; and
- ✓ Identify successful strategies for improving access to dental care and disseminate information on those models.

Objective 9 Improve Access to Mental Health Services for Older Adults.

Background

Almost 20 percent of people over age 55 experience mental disorders that are not a part of "normal aging." Among adults aged 65 and over an estimated 11 percent suffer from anxiety; 6.4 percent have cognitive impairments; and 4.4 percent experience depression and other mood disorders. Suicide rates increase with age, with older white men being at six times greater risk for suicide than the general population.

These conditions can severely limit social interaction, quality of life, and general health. While the efficacy of mental health treatment is well documented, older adults often do not recognize the need for or availability of treatment, resulting in gross underutilization of mental health services.

With the passage of Proposition 63, the 2004 Mental Health Services Act (MHSA), California has the opportunity to reconceptualize how mental health services for older adults and adults with disabilities are organized and delivered and to increase mental health services for older and disabled adults. In order to obtain MHSA funding, each county mental health department must develop a three-year plan created through a comprehensive local planning process with broad stakeholder participation. Counties, at this point are in the early stages of developing these plans.

Key Actions

- ✓ Actively participate in State level MHSA implementation efforts to assure that the mental health needs of older adults are well represented in planning and implementation steps;
- ✓ Encourage CDA stakeholder participation in local county MHSA strategic planning efforts; and
- ✓ Create opportunities for stakeholders to learn about "promising practices" in older adult mental health education, screening and treatment models in order to disseminate successful interventions and encourage collaborative efforts between mental health and aging service providers.

Objective 10 Collaborate with agencies and coalitions providing geriatric training to current health, social service, and mental health professionals as well as those who are training in these professions to increase the number and improve the skills of those who are providing services to older Californians.

Background

To provide appropriate services to older adults, providers need specialized training on various gerontology and/or disability issues. They also need at least a basic understanding of key programs serving older and disabled adults (e.g. Medicare, Social Security, Medi-Cal, OAA services, etc.) and how to help link their clients to needed services. While California's aging population is growing, the workforce needed to serve this population is shrinking. In many professions, such as social work, health and mental health, most of the current workforce lacks geriatric education and experience.

To ensure that older adults and persons with disabilities receive the most cost effective high quality services, current providers and those in training need to develop skills based on the growing body of evidenced-based research in health, mental health and social service interventions. Significant attention must also be directed to recruiting students into these fields given the growing workforce needs.

Key Actions

- ✓ Continue to serve on the California Geriatrics Center Statewide Advisory Committee and support its training initiatives throughout the state to effectively

prepare today's and tomorrow's health, mental health and social service professionals to better serve older adults and persons with disabilities;

- ✓ Seek opportunities for CDA's staff to learn more about key aging and disability issues; and
- ✓ Speak on aging issues and workforce opportunities to student groups and help link students to local internship opportunities.

Protect the Quality of Life and Rights of Elders through Education, Legal Services, and Improved Coordination with Law Enforcement

Major Accomplishments (2000-2004)

- Received an additional $2.3 million in FY 2003-04 to increase Long Term Care (LTC) Ombudsman program volunteer recruitment efforts, using radio, television, and print advertisements. Over 350 new volunteers have been recruited to date;

- Developed a Memorandum of Understanding between the LTC Ombudsman program and the Department of Justice Bureau of Medi-Cal Fraud and Elder Abuse to improve coordination between the two programs and better protect the rights of elders in LTC facilities;

- Created statewide guidelines for delivering legal services and initiate the process for the development of statewide uniform reporting standards to ensure the consistency, quality, and rules of practice among legal service providers statewide; and

- Conducted annual training conferences to enhance legal service providers' knowledge in specific topics to include elder abuse, predatory lending, access to benefits, and bankruptcy.

Current and Future Concerns

- With more older adults living alone, an increasing number of families do not see the early warning signs that a relative needs help. As a result, intervention to prevent injuries, abuse or neglect may not happen until a crisis occurs, which may make it difficult for that person to continue living independently; and

- Isolated, lonely individuals, particularly those who may be developing dementia, are at increased risk of financial abuse, whether by unscrupulous individuals marketing home repairs, refinancing, insurance, and other products or by their own family members, neighbors or chore workers.

Priorities for 2005-2009

Objective 11 Increase awareness among local law enforcement on how to recognize and investigate elder and dependent adult abuse and neglect in LTC facilities.

Background

Even though State statute mandates law enforcement training on elder and dependent adult abuse reporting, investigation, and prosecution, most law enforcement personnel generally lacks an awareness and recognition of the fact that elder and dependent adult abuse that occurs in facilities is a criminal activity. As a result, they are unprepared to effectively conduct this type of investigation, which results in fewer prosecutions.

Key Actions

- ✓ Identify successful local strategies that have increased law enforcement training on elder and dependent adult abuse and neglect and encourage replication of these efforts throughout the state; and
- ✓ Facilitate skill building for local law enforcement on interviewing older and dependent adults and understanding the victim's psychological state and needs in the aftermath of potentially abusive situations.
- ✓ Collaborate with other social services and law enforcement agencies to make it easier for older people to access legal services and insure that they are protected from physical, emotional and fiduciary abuse; and

Objective 12 Improve the quality and quantity of legal services provided to older adults.

Background

As a result of the rapid increase of California's older adult population, an increased number of elders are at risk of exploitation and abuse by relatives, landlords, dishonest care providers, discriminatory employers, unscrupulous merchants and predatory lenders.

Over the past four years, CDA has significantly increased its efforts to improving legal services for older adults. In the coming four years, the Department will build upon this foundation, as the new statewide guidelines and data reporting standards are implemented.

Key Actions

- ✓ Incorporate the Statewide Guidelines for Legal Assistance in California and the uniform data reporting requirements into the contracts with legal services providers. Respond to questions that will arise in implementing statewide legal services guidelines and data reporting standards;
- ✓ Analyze data reported on the specific legal needs of seniors and the types of legal services currently provided throughout the state;
- ✓ Explore opportunities to create web-based training and shared best practices among legal services providers;
- ✓ Coordinate with program staff to provide technical assistance, establish provider performance goals, and develop cost-effective methods to ensure periodic monitoring and evaluation of legal services providers;
- ✓ Assess cultural and linguistic needs of older adults seeking services; and
- ✓ Develop core elements for AAAs to use in Requests for Proposals from legal services agencies.

Strengthen the Quality and Accountability in CDA Programs

Major Accomplishments (2000-2004)

- Redesigned tools and processes used to perform AAA on-site monitoring to be clearer, more comprehensive and provide immediate feedback on issues that need correction;
- In partnership with DHS, secured the federal reauthorization of the MSSP wavier;
- Redesigned the Adult Day Health Care certification survey process to focus on client service and quality issues; and
- Created databases of monitoring findings to focus staff training and target corrective action resources.

Current and Future Concerns

- ✔ More older adults who have complex acute and chronic health and mental health conditions are living longer in their own home and communities. The increased complexity of their care requires very strong quality assurance mechanisms among service providers, timely coordination between these providers and a well functioning "safety net" in emergency situations; and
- ✔ High turnover in agencies serving older adults and their informal caregivers, due to retirements and more frequent job changes, could potentially result in lost expertise and leadership, gaps in program continuity, and decreased quality of services.

Priorities for 2005-2009

Objective 13 Provide consistent AAA technical assistance in the most efficient manner.

Background

Reduced staffing at both the state and local level, coupled with increased retirements of long time employees and more rapid turn over in jobs, has created an environment in which there are many new employees who do not have significant expertise in administering aging programs. To ensure that federal program requirements are being met and to assure the quality of services being provided to older adults and their family caregivers, CDA must find efficient and effective options to deliver technical assistance to the AAAs.

Key Actions

- ✓ Research current methods for providing technical assistance;
- ✓ Develop a technical assistance database that contains guidance provided by CDA via e-mail, telephone conversations, etc. and CDA on-site AAA monitoring visits that includes monitoring findings and targeted corrective actions required to address the findings (The database will help CDA track specific issues that need to be resolved and deadlines for resolution);

- ✓ Highlight Best Practices discovered through on-site monitoring that should be posted on CDA's website;
- ✓ Survey internal/external stakeholders to determine key training and technical assistance needs;
- ✓ Design and implement web-based database and post training curriculum and technical assistance documents; and
- ✓ Develop an I&A Section on CDA's website (also discussed in Objective 1).

Objective 14 Develop and maintain program standards and requirements for home and community based services authorized by the Older Californians Act, in a manner consistent with the Older Americans Act.

Background

In addition to OAA programs, authorized and funded at the federal level, California has also historically funded additional services for older adults and adults with disabilities. These community-based service programs (CBSPs) seek to maintain the self-sufficiency and well-being of older adults and adults with disabilities so they can remain safely in their own home and community for as long as possible. These programs are supported by the State General Fund, although they often receive significant additional support from local sources, grants, etc.

Reduced State revenues over the past several years have decreased direct service funding for these programs and also reduced State resources to monitor these programs. Without State monitoring to ensure that core program standards are being met, health and safety concerns may develop over time.

CDA proposes to coordinate with CBSP stakeholders and consumer advocacy groups to develop standards, best practices and other guidance to support the viability of these programs. A broad array of stakeholders should participate in these efforts to improve service coordination and encourage seamless access to services. Information and assistance stakeholders must also be included to help ease access to services and inform the public. Consumers of these services should be actively involved in these efforts.

Key Actions

- ✓ Brown Bag (BB): Ensure quality service delivery consistent with the OAA Title III Elderly Nutrition Program;
- ✓ Alzheimer's Day Care Resource Centers (ADCRC): Ensure quality service delivery consistent with the OAA Title III B Adult Day Services Program; and
- ✓ Linkages: Ensure quality service delivery consistent with the OAA Title III B Case Management Program.

Objective 15 Develop Monitoring and Assessment Tools to Ensure that Basic Minimum Program Requirements Are Met.

Background

Title IIIB of the Older Americans Act allows for provision of many supportive services designed to assist older individuals in living independently in a home environment and to assist individuals in long term care facilities, who are able to move to a more independent living setting.

Currently, I&A, Legal Services, Case Management, and Adult Day Care are the only Title IIIB Other Supportive Service programs for which minimum standards, criteria, and State regulations exist or are being developed to ensure that these standards are met. Basic standards will be developed to help focus the monitoring of Title III-B "Other" Supportive Services in accordance with Title III-B requirements.

CDA needs to continue to develop criteria and standards for Title IIIB "Other" services, including but not limited to: Personal Care, Homemaker, Chore, Assisted Transportation, Transportation, Outreach, Housing and Minor Home Modification, Security/Crime, Health/Mental Health, Community Services/Senior Center Management, Employment, Consumer Services, Respite Care, Visiting and Telephoning. Other examples include tax counseling, financial counseling, shopping, escort, reader, and letter writing services, volunteer opportunities, and many of the other activities described in Part B, Section 321 of the OAA.

CDA proposes to coordinate with the California Association of Area Agencies on Aging (C4A), representatives from the disability community, and other stakeholders to develop standards, best practices, and other guidance to support the viability of these programs. I&A stakeholders must also be included to facilitate access to these services. Service consumers should be actively involved in these efforts as well.

Key Actions

- ✓ Develop a draft tool and protocol to monitor Title III-B "Other" Supportive Services;
- ✓ Test this monitoring tool and refine as necessary;
- ✓ Distribute the draft tool to C4A and providers for comment and input;
- ✓ Solicit input from I&A stakeholders to help ensure program standards and monitoring activities reinforce consistent and seamless access to Title III-B "Other" Supportive Services; and
- ✓ Begin monitoring all AAAs to ensure Title III-B "Other" Supportive Services requirements are being met.

Objective 16 Partner with DHS Medi-Cal to Redesign the current Adult Day Health Care program to conform with federal Medicaid requirements.

Background

In December 2003, the federal CMS notified the California DHS that the state's Medi-Cal adult day health care (ADHC) program did not meet the federal Medicaid State Plan

requirements. DHS would be required to redesign the ADHC benefit or risk losing federal fiscal participation. After considerable dialogue with CMS and the provider association representing ADHCs, CMS agreed to continue financial participation if the program was redesigned to meet the Medicaid Rehabilitation Option. Development of a State Plan Amendment to make these program changes is underway. These changes will require DHS and CDA to retool many aspects of the Medi-Cal certification process that the CDA ADHC Branch performs.

Key Actions

- ✓ Revise ADHC definitions to conform to the Rehabilitation Option;
- ✓ Revise ADHC medical necessity criteria for authorization of ADHC services;
- ✓ Develop new, unbundled reimbursement rates for ADHC skilled services. Revise ADHC Program section of Medi-Cal Provider Manual;
- ✓ Collaborate with DHS in securing legislative authority for the ADHC Program to operate as an optional Medi-Cal benefit and submitting State Plan amendment to CMS; and
- ✓ When approved, train CDA staff and providers on requirements and procedures consistent with the re-conceptualized ADHC Program.

Objective 17 Develop a new model for ADHC program oversight.

Background

Redesigning the Medi-Cal ADHC benefit to comply with the Medicaid Rehabilitation Option will also require that CDA and DHS Licensing and Certification redefine their respective roles and responsibilities in overseeing the ADHC program, with the goal of eliminating duplication and creating oversight efficiencies.

Key Actions

- ✓ Revise current regulatory and statutory requirements for licensure and certification and integrate them into a new ADHC Medi-Cal Provider Manual;
- ✓ Work with DHS to define our respective roles and responsibilities in licensing and certifying ADHC centers;
- ✓ Based on these redesigned roles, revise CDA's interagency agreement (IA) with DHS for shared oversight of the ADHC program and develop new internal policies and procedures that reflect these roles and responsibilities;
- ✓ Revise the ADHC certification survey protocol to reflect new commitments and responsibilities;
- ✓ Train CDA and DHS staff, and ADHC providers, on the revised survey process; and
- ✓ Implement the revised survey process.

Objective 18 Improve the quality of life for older adults in the Multipurpose Senior Services program (MSSP) by developing a comprehensive Quality Assurance program.

Background

MSSP is a Medi-Cal waiver program serving elderly persons 65 years and older who are Medicaid eligible and certified as otherwise needing a nursing home level of care, without these community-based supportive services. In partnership with the Multipurpose Senior Services Program Site Association (MSA), CDA must expand the existing MSSP Quality Assurance (QA) program to demonstrate to CMS that CDA is in compliance with federal standards and to further the State's goal of unnecessary institutionalization and freedom of choice consistent with the Olmstead decision. Additionally, reviewing the quality of the program will allow MSSP to foster coordination of services and resources with other California waiver and grant projects. Coordination of activities will facilitate effective use of federal and State resources.

Key Actions

- ✓ Establish workgroup that includes MSA and DHS to review and expand the MSSP QA/QI plan;
- ✓ Provide updates on workgroup progress at quarterly MSA meetings and monthly DHS oversight meetings. DHS, as the oversight agency, will provide CMS with reports of CDA's QA activities and progress;
- ✓ Coordinate and collaborate with other Medi-Cal waiver programs to reduce duplication of services and enhance the development of common resources and tools for assessment and service delivery needs. This QA framework will be shared, as appropriate, across CDA programs such as Linkages and Title III Case Management so that it can be used as a basis for evaluating quality within the Long-Term Care Division; and
- ✓ Use this revised QA/QI process for the coming five-year period between waiver approval (2005) and waiver renewal (2009). Each year, the plan will provide for greater validation of the program's effectiveness in moving toward CMS' goals of freedom of choice in community options, quality of service, and fiscal accountability in service delivery.

Objective 19 Improve LTC Ombudsman program consistency and quality.

Background

Monitoring of local Ombudsman programs has been sporadic due to unclear CDA, AAA and local Ombudsman oversight roles. Previous steps in developing program regulations have not been completed and need to be resumed. Program data is collected but has not been analyzed. Over the next four years, the OSLTCO will monitor programs, develop regulations and analyze data to improve the quality and consistency of Ombudsman programs statewide. In addition, information collected through monitoring and data analysis will be used to address systemic issues in LTC facility settings.

Key Actions

- ✓ Conduct monitoring visits to all 33 AAAs and site visits to all 35 local Ombudsman programs over the coming four years;
- ✓ Ensure follow-up on all corrective action and recommendations made during monitoring and site visits within 90 days of issuance of the monitoring reports;
- ✓ Promulgate regulations for the administration and operation of the statewide Ombudsman program; and
- ✓ Analyze complaint and program data to identify trends and systemic issues in LTC facilities.

Objective 20 Incorporate AoA Family Caregiver Support Program (FCSP) data reporting measures in CDA data reporting requirements and monitor program use and best practices at the local level.

Background

The FCSP was created at the federal level in 2000 to provide a comprehensive system of supportive services for caregivers in each state. This new program recognizes the extensive assistance informal caregivers provide so they can remain at home in their own community. In FY 2001-02, approximately $18.9 million in new federal funding was allocated to the California's AAAs to begin providing caregiver supportive services. Since the initial implementation of this program in 2000, federal funding has continued to increase and services have continued to grow even when federal funding for other key OAA programs has declined.

Given the relative newness of the program, CDA initially developed a temporary paper reporting system. This system requires AAAs to report demographic characteristics on both caregivers and the recipients of their care. In addition, service units and fiscal data are collected on more services and in greater detail than the federal government minimally requires. This "first generation" system is experimental to allow CDA to test what to measure in the new program. It will be replaced by a "second generation" system over the next four years.

AoA has also issued a new reporting requirement for National Aging Program Information System (NAPIS), to incorporate information on grandparents raising grandchildren. CDA's new "second generation" data reporting system will also incorporate these new NAPIS reporting requirements.

Finally, in order to have adequate data to perform long range planning, CDA's data system will need to go beyond the minimum AoA reporting requirements. It is envisioned that this "second generation" system will also address the state's need for more comprehensive data across multiple programs.

Key Actions

- ✓ Incorporate the AoA FCSP performance measures in CDA's electronic data reporting requirements so that information is available to monitor program efficiency, customer satisfaction, and service targeting;

- ✓ Analyze basic service and client profile information, and compare the data with performance outcome measures (e.g., POMP, the on-going caregiver survey being conducted by University of California Berkeley, etc.);

- ✓ Formulate statewide standards and policies for FCSP-funded support services, and promote "best practices;" and

- ✓ Monitor AAAs to ensure effective and responsive management of FCSP funded services.

Expand opportunities for volunteerism among older adults and increase the number of volunteers among all ages in programs serving older adults

Major Accomplishments (2000-2004)

- In 2003, as a component of California's LTC Consumer Protection Initiative, the Ombudsman program received additional funding from the federal Nursing Home Federal Citation Penalty Account to recruit, train and supervise an additional cadre of Ombudsman volunteers throughout the state. Over 350 new Ombudsman volunteers have been recruited to date.

Current and Future Concerns

- Volunteer recruitment efforts are not keeping pace with attrition and growth of the aging and disabled population;
- Paid staff must be increased in order to recruit, train, oversee and retain an increased number of volunteers;
- Programs must recruit new volunteers that reflect the state's great diversity to make those programs more accessible to hard-to-reach ethnic and cultural groups; and
- Overall volunteerism in California is low compared to other states and older Californians rank lower than the state's other age groups in their volunteerism efforts.

Priorities for 2005-2009

Objective 21 Expand opportunities for older adults to volunteer their time and expertise in activities that benefit the public good and increase the number of volunteers of all ages in programs serving older adults.

Background

Each year thousands of older adults use supportive services, many of which rely largely on the efforts of volunteers. These volunteers work through federal, state and local organizations that offer opportunities and services to older adults as well as those in need of services.

Cohorts of older Californians have volunteered with local organizations for many years providing stability and continuity in those programs. A 1998 CDA report identified 67,620 Californians providing volunteer service in aging programs at the local level. Nevertheless, the volunteerism rate among older Californians (17 percent) is substantially lower than the 25 percent overall rate of volunteerism in California. A 2000 California poll found that while only 17 percent of older adults had volunteered in the past year, 53 percent planned to volunteer and 34 percent wanted to increase their level of volunteering. (Source: U.S. Bureau of Labor Statistics, 2004) These statistics

present reason for concern as well as optimism because a 2001 poll conducted by the California Governor's Office on Service and Volunteerism found that while only 17% of older adults currently volunteered, 53% planned to and 34% wanted to increase their level of volunteering.

Effective, more visible recruitment efforts are needed to address the attrition that occurs when volunteers move, develop health conditions, must provide family caregiving, etc. As California's older adult population increases, additional volunteers must be recruited just in order to maintain service levels. A much more intensive effort will be required to actually increase the overall number of volunteers. For example, the 2003-2004 LTC Ombudsman recruitment campaign added 387 new volunteers. But during the same period, 341 volunteers left the program, so the net volunteer increase was only 46 persons. Without this stepped up level of recruitment (and increased retention efforts as well) programs like HICAP, Meals on Wheels, the LTC Ombudsman and many, many others will not be able to maintain their service levels.

Action Steps

- ✓ Assess the critical needs of programs that rely heavily on volunteers (e.g., HICAP, LTC Ombudsman, Nutrition, etc.) based on patterns of volunteer recruitment and retention;
- ✓ Promote the use of volunteer programs, such as the Senior Companion Program to help meet the growing consumer demand for more respite hours for caregivers;
- ✓ Convene stakeholder workgroups to identify how State and local collaboration can effectively increase volunteers in these local programs; and
- ✓ Identify opportunities to more effectively encourage and coordinate volunteerism at the state level through collaboration with the California Service Corp within the Governor's Office, Department of Education and other appropriate agencies.

Use existing and emerging technology to improve program management and accountability, policy development, and service delivery

Major Accomplishments (2000-2004)

- Since 2004, CDA has been posting provider program memos, budget allocations, training materials and other useful administrative information on its web site. This makes the most up-to-date essential program information readily available to CDA's business partners and local agency contactors. It is a basic step in CDA's commitment to providing greater public transparency and accountability on how funding is used, what services are provided, and our progress in meeting our performance goals at the state and local level;

- CDA has succeeded in transitioning all AAAs to electronic data reporting and has completed the management data system necessary to collect and transmit the NAPIS data to the AoA electronically; and

- CDA's website has grown and its use has doubled in the last year—going from 7,839 external visitors in January 2004 to 16,749 visitors in January 2005.

Current and Future Concerns

- ✔ As the Internet becomes the primary resource for many key documents, ensuring website security and 24/7 availability becomes more critical;
- ✔ Web access is still not universally available in some remote parts of the State and among some hard-to-reach populations; and
- ✔ Continued development of web-based resources requires increased staffing, training, equipment, and budgetary resources.

Priorities for 2005-2009

Objective 22 Develop a pre-screening calculator on CDA's web site so that interested older adults could determine if they are eligible to participate in the Senior Community Services Employment Program (SCSEP).

Background

The SCSEP program, funded through Title V of the OAA, provides useful part-time job training opportunities in community services assignments for unemployed low-income persons age 55 and over. Enrollment in this program is designed to create additional job skills and experience to help participants find more permanent, non-subsidized employment in the future.

Adding the pre-screening calculator on the website would help older Californians learn about and determine if they are eligible for the program (while re-directing ineligible persons to the One-Stop Career Centers); increase community awareness of SCSEP and the value of older workers; increase enrollment of eligible participants; and increase awareness of AAAs and the support services they provided.

Key Actions

- ✓ Design and test the SCSEP pre-screening calculator; and
- ✓ Promote the use of the SCSEP web page features.

Objective 23 Automate the scheduling and management of the ADHC Branch's Medi-Cal certification reviews.

Background

CDA is responsible for the Medi-Cal certification of the State's 360 Adult Day Health Care (ADHC) facilities. CDA's ADHC unit must maintain an ADHC database; schedule monitoring visits; and correspond with facilities on monitoring findings, technical assistance requests, etc. To date, most of this workload has not been automated. Developing a database accessible to all CDA ADHC staff will enable the Branch to collect ADHC provider profile information; track key due dates and actions related to ADHC center certification (survey scheduling, compliance history, etc.); and allocate staff resources to accomplish critical tasks.

Key Actions

- ✓ Work with the CDA Information Technology Branch (ITB) to develop new database applications; and
- ✓ Place selected ADHC Program data on CDA's web site for provider and public use.

Objective 24 Expand and improve CDA's database capabilities to incorporate more comprehensive data and reporting.

Background

CDA currently only collects aggregate data from its contractors. While this meets minimum federal reporting requirements, it is not very useful for planning purposes. For example, the current data could report the ethnicity of home-delivered meal clients, but not how many Hispanic home-delivered meal recipients were living alone. To effectively plan for a rapid increase in our aging population and to coordinate services across programs, a more comprehensive data system will be needed.

A special report from the California Policy Research Center provided a framework to produce this information, in part by linking to existing data already being collected (e.g.,

U.S. Census, California Health Interview Survey, etc.).[15] CDA's goal is to make incremental internal improvements in the software applications it uses and the data it collects to provide better information for public policy planning and evaluation.

Key Actions

- ✓ Replace the existing database system used for AoA data reporting with a web-based system that will collect client specific, rather than aggregate, data;
- ✓ Establish and adopt a common (i.e. "shared") dataset for our contractor and provider networks to promote better coordination and collaborative planning across programs; and
- ✓ Develop strategies for combining federal census data, health data (i.e., Californian Health Interview Survey), utilization data, and fiscal data to estimate and project service needs and compare potential need to actual service use.

Improve CDA's Business Practices to Support Policy and Programmatic Goals

Major Accomplishments (2000-2004)

- Introduced dedicated web pages for CDA business partners that provide information to assist them in administering their programs; and
- Streamlined financial audit process and improved audit reports.

Current and Future Concerns

- ✔ Increased demand for accessible information on the web and within internal databases requires increased staffing, training, equipment and budgetary resources.

Priorities for 2005-2009

Objective 25 Improve and maintain strong financial management practices and enhance accountability of CDA administered programs.

Background

Fiscal accountability for federal and state funds is a core CDA responsibility. Recent CDA Audit unit activities have focused increasing the clarity, accountability and timeliness in the CDA audit process, audit reports issued to contractors, and submitted plans of corrections on audit findings. CDA's goal is to proactively make contractors (and independent auditors used by contractors) more aware of program fiscal requirements in order to avoid audit findings.

Key Actions

- ✓ Develop a pilot program with AAAs to educate their subcontractors (direct service providers) on the requirements they must meet to comply with federal and state law, regulations and contract requirements;

- ✓ Implement web-based tutorials for AAAs to provide technical assistance on fiscal monitoring of local service providers and develop web-based basic training needed to respond to the on-going technical assistance requests due to chronic turn over in AAA fiscal staff;

- ✓ Develop an annual AAA survey to determine AAA preparedness for an audit to use AAA and CDA resources more efficiently; and

- ✓ Create a guide for independent auditors performing single audits for AAAs to inform them of applicable federal and state laws, regulations and contact requirements.

Objective 26 Use technology to provide improved fiscal management information to department managers and external business partners/contractors.

Background

While the CALSTARS accounting system permits CDA to accurately account for funds and prepare externally-required financial reports, it is not structured to provide information that can be easily accessed by managers to adequately monitor and manage their budgets. CDA managers need more timely "user-friendly" reports to assess their budget status and make informed decisions on resource allocations.

Key Actions

- ✓ Review existing reports with managers to determine their fiscal information needs;
- ✓ Analyze and incorporate needed technical changes to current accounting systems coding and tables;
- ✓ Develop and automate monthly expenditure projections;
- ✓ Review federal and state requirements for time reporting and automate timesheet reporting;
- ✓ Work with fiscal team to improve "F01" report for reconciliation of advances and expenditures with ManAge information (ManAge is CDA's current database used for federal and state reporting and monitoring purposes); and
- ✓ Work with CDA teams to increase availability of web-based fiscal and allocation information to AAAs.

Objective 27 Use technology to improve CDA program management and service delivery.

Background

Automation of various functions and program tasks within CDA can help compensate for reduced staffing resources. Centralized databases and increased information on CDA's website can ensure that CDA staff, business partners/contractors, and the public have access to up-to-date information and will aid in the training of both CDA and local level staff.

Key Actions

- ✓ E-government—continue to expand CDA's website to provide increased external access to CDA program information. Tasks referenced elsewhere in this Plan include:
    - o Providing a SCSEP pre-screening calculator on CDA website (Objective 21); and

- Posting program and administrative information on the website to assist CDA business partners.

✓ Develop and implement "subscription-type" service for information sharing to be added with CDA stakeholders (so interested parties can join, update or un-subscribe to an electronic mailing list as desired without requiring additional CDA staff resources);

✓ Identify affordable technology interventions to improve training presentations and information sharing between CDA and its contractors;

✓ Implement internal CDA intranet so staff can quickly find and use needed forms, templates, guidelines, etc.

✓ Databases and Automated Processes—Several of these tasks are referenced elsewhere in this Plan:

- Procure and transition to a data reporting system that meets NAPIS reporting requirements;
- Integrate non-NAPIS data into enterprise-wide (web-based) central database;
- Procure an information management system in order to centralize program history and tracking and implement paper imaging and basic electronic flow of work from one staff person to the next in order to reduce paperwork, copying and time spend coordinating the completion of assignments;
- Plan for and phase-in enterprise-wide accessibility to other CDA database information, with central entry point
  - Implement technical assistance database for AAAs;
  - Design and implement FCSP monitoring database; and
  - Automate administrative systems to improve efficiencies.
- Explore options and phase-in automation and workflow for administrative functions, i.e. central employee information database with automated timesheet function.

Objective 28 Effectively manage CDA's Human Resource needs.

Background

Due to an anticipated increased number of retirements, CDA needs to develop a succession plan to ensure critical staffing needs continue to be met and institutional knowledge is preserved.

Key Actions

✓ Conduct a survey of projected retirements in the coming five years;

- ✓ Develop and regularly update a workforce plan;
- ✓ Establish an upward mobility plan (that includes mobility to management levels);
- ✓ Conduct exams to fill projected vacancies (open and promotional); and
- ✓ Collaborate with other departments to share ideas and resources;

Objective 29 Improve the contracting process through better use of technology in order to streamline the process and reduce costs.

Background

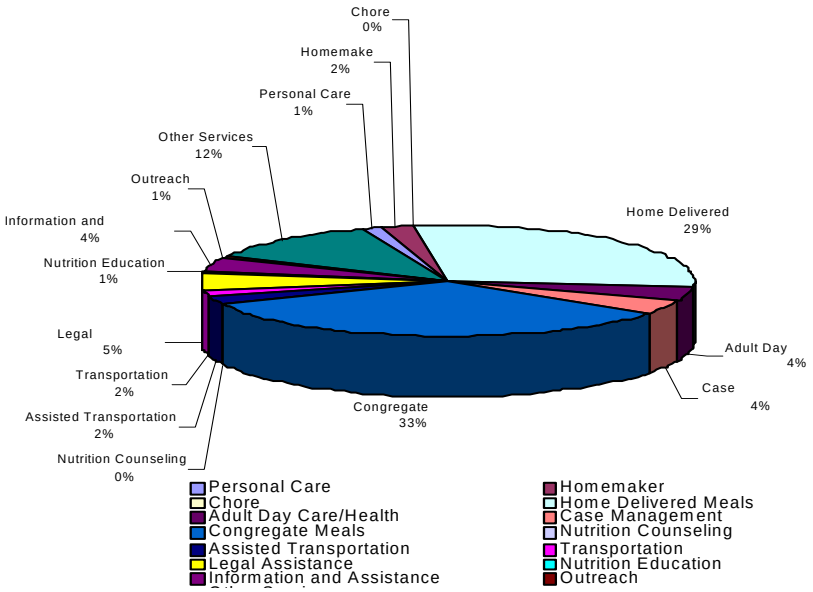
CDA administers its programs primarily through contracts with local agencies. By posting these contract terms and conditions on CDA's web site, CDA can reduce staff time spent on the contracting process and keep the parties informed of updated terms and conditions. This will make it easier for CDA contractors to "cut and paste" mutual contract terms and conditions into their own subcontracts, reducing the time local agencies must spend in their own contract updating.

Key Actions

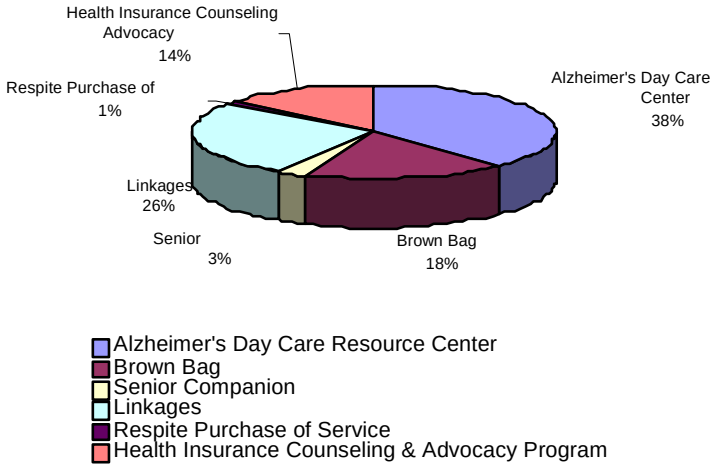
- ✓ Create updated versions of CDA's contract terms and conditions for four programs (HICAP, MSSP, Title V, and Area Plans) beginning with Area Plan contracts;
- ✓ Obtain approval from Department of General Services and Office of Legal Services on terms and conditions;
- ✓ Post terms and conditions on Department of General Services and CDA's web-site; and
- ✓ Reformat contract front page (STD 213) to reference terms and conditions by web-page location, eliminating all hard-copy terms and conditions and enabling all stakeholders ready access on the Web to the current terms and conditions of CDA contracts.

V. Federal Assurances

2003-2004
Older Americans Act Services
by Total Expenditures



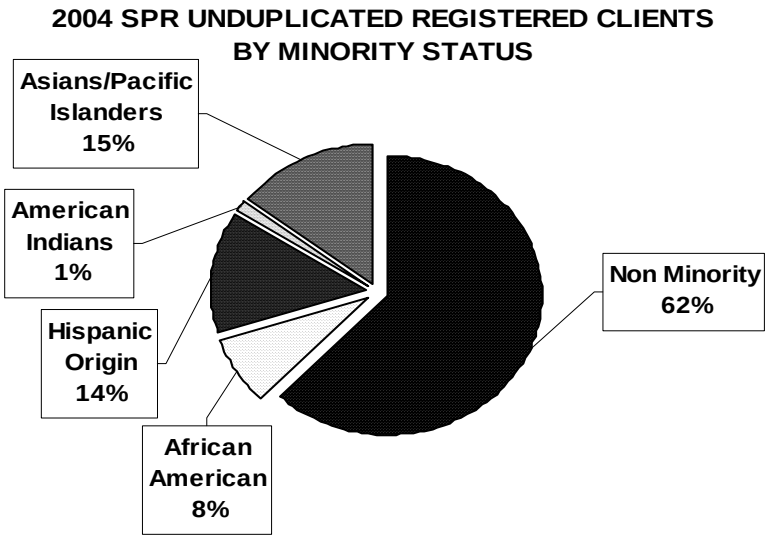
2003-2004
Older Californians Act
Community-Based Services By Total Expenditures

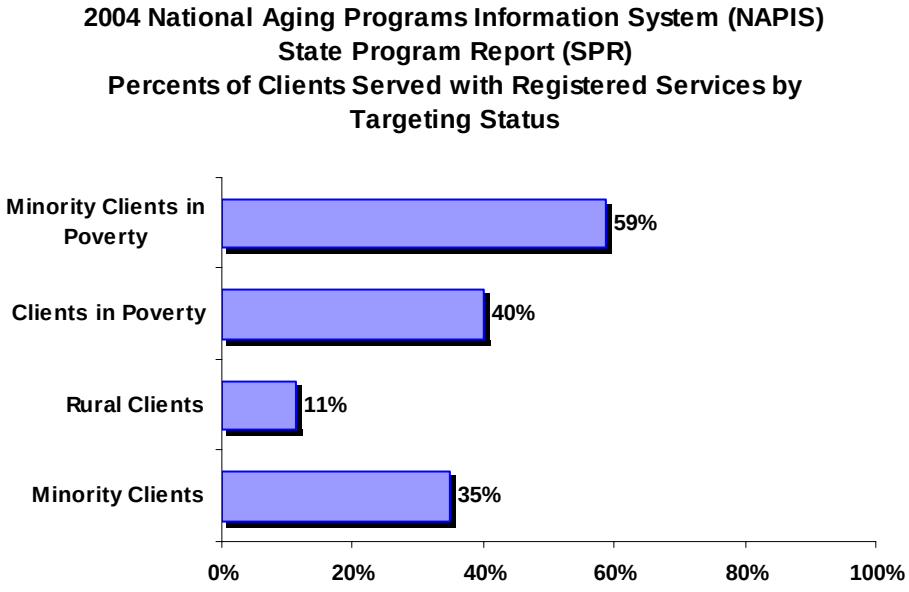


Approved Minimum Title III B Expenditures For Priority Services: Access, In-Home Services, and Legal Services
From Appendix V of the Area Plan
FY 2004/05

PSA #	Access	In-Home	Legal
1	25.0%	9.0%	16.0%
2	30.0%	4.0%	14.0%
3	20.0%	10.0%	10.0%
4	25.0%	20.0%	8.0%
5	20.0%	10.0%	5.0%
6	48.6%	6.6%	44.8%
7	50.0%	8.0%	11.0%
8	46.6%	2.1%	15.9%
9	17.9%	15.0%	11.2%
10	48.0%	13.0%	16.0%
11	16.0%	29.0%	13.0%
12	25.0%	8.0%	2.0%
13	27.5%	1.5%	15.0%
14	45.0%	8.0%	5.0%
15	39.6%	1.0%	10.8%
16	20.0%	22.0%	12.0%
17	7.0%	20.0%	5.0%
18	21.6%	1.0%	8.0%
19	30.0%	25.0%	8.0%
20	62.0%	2.0%	13.0%
21	25.9%	6.0%	4.0%
22	48.0%	11.0%	12.0%
23	47.1%	26.2%	7.2%
24	25.0%	13.0%	12.0%
25	57.1%	15.8%	5.2%
26	45.0%	10.0%	23.0%
27	22.0%	10.0%	12.0%
28	31.8%	10.5%	12.8%
29	18.0%	1.3%	30.0%
30	33.0%	20.5%	22.0%
31	40.0%	1.0%	20.0%
32	27.0%	3.0%	31.0%
33	34.0%	28.0%	20.0%

3/31/2005


2004 SPR UNDUPLICATED REGISTERED CLIENTS
BY MINORITY STATUS
Asians/Pacific Islanders 15%
American Indians 1%
Hispanic Origin 14%
African American 8%
Non Minority 62%


2004 National Aging Programs Information System (NAPIS)
State Program Report (SPR)
Percents of Clients Served with Registered Services by
Targeting Status
Minority Clients in Poverty
59%
Clients in Poverty
40%
Rural Clients
11%
Minority Clients
35%
0%
20%
40%
60%
80%
100%

CALIFORNIA DEPARTEMNT OF AGING
INTRASTATE FUNDING FORMULA (IFF)

DESCRIPTIVE STATEMENT OF FORMULA

The California Department of Aging is required under Title III of the federal Older Americans Act (OAA) to develop a formula for the distribution of funds within the State under this title. This formula must take into account, to the maximum extent feasible, the best available statistics on the geographical distribution of individuals aged 60 and older in the State and publish such formula for review and comment. The IFF allocates funds to planning and service areas (PSAs) to serve persons aged 60 and older (60+).

While the OAA is concerned with the provision of services to all older persons, it requires assurance that preference is given to older individuals with greatest economic or social needs, with particular attention to low-income minority individuals. Under the OAA, the term "greatest economic need" means the need resulting from an income level at or below the poverty levels established by the Office of Management and Budget. The term "greatest social need" means the need caused by non-economic factors that include physical and mental disabilities, language barriers, and cultural, social, or geographical isolation including that caused by racial or ethnic status which restricts an individual's ability to perform normal daily tasks or which threatens such individuals' capacity to live independently.

CDA's IFF was developed: to support the provision of needed services to older persons; to reflect the relative emphasis required by the OAA; to provide consistent emphasis to individuals with certain characteristics, regardless of their area of residence; and to be responsive to California's diversity.

The requirement to give "preference" and "particular attention" to older individuals with certain characteristics recognizes that other older individuals with needs also are served under the OAA. The CDA takes this into account by assigning a weight of one (1.0), the least weight, to the population factor of 60+ Non-Minority, identified here as "other individuals."

CDA then applied the definitions of greatest economic need and greatest social need in selecting the three remaining factors listed below, and assigned weights to develop a weighted population and to achieve the relative emphasis required by the OAA.

INDIVIDUALS	FACTORS	WEIGHTS
Greatest Economic Need:	60+ Low Income	2.0
Greatest Social Need:	60+ Minority	2.0
	60+ Geographical Isolation (Rural)	1.5
Other Individuals:	60+ Non Minority	1.0
Medical underserved (IIID only):	60+ Medi-Cal Eligibles	1.0

When combined, these population factors and weights result in an allocation of Title III funds which is consistent with the OAA and which is based on the relative degree of emphasis (from 5.5 to 1.0) for the individuals noted below.

	RELATIVE EMPHASIS	
	RURAL AREAS	OTHER AREAS
Low Income Minority Individuals	5.5	4.0
Low Income Individuals (not Minority)	4.5	3.0
Minority Individuals (no Low Income)	3.5	2.0
Other Individuals	2.5	1.0

CDA assumes that the IFF must: be equitable for all PSAs, and reflect consistent application among PSAs of greatest economic or social need, with particular attention to low-income minority individuals; include factors which are mutually exclusive whenever possible; utilize data that are available, dependable, and comparable statewide, and that are updated periodically to reflect current status; reflect changes in population characteristics among PSAs; and be as easy as possible to understand.

NUMERICAL STATEMENT OF THE FORMULA

The following is a description of the Intrastate Funding Formula (IFF used for allocating OAA Title III and VII funds in accordance with Section 45 CFR 1321.37

1. The process begins by identifying:
   a. Total Federal and State matching funds available for allocation to Planning and Service Areas (PSAs) for each Title III and VII program. (Total in Demonstration Column O)
   b. Population data, updated no more than annually as information is available, by county and arraying these data by PSA. (Population Data Columns A-F on Demonstration)
2. The Statewide total amount for the administration allocation is calculated by taking ten percent (10%) of the Federal funds. (The Total in Demonstration Total Column G)
3. The Statewide total amount for the program allocation is calculated by subtracting the administration allocation from the total for State and federal funds. (The Total in Demonstration Column M and N)
4. Administrative funds are allocated as follows:
   a. Each PSA receives a fifty thousand dollar ($50,000) base.

b. The balance of total administrative funds identified in 2. above is allocated to PSAs based on each PSA's proportion of California's total persons aged 60 and older.
c. Each PSA's total administration allocation is distributed among its qualifying Title III programs based on total qualifying administrative funds available.

5. Program funds are allocated based on weighted population figures. Weighted population totals are determined for each PSA by combining the following factors:
   a. The number of non-minority persons aged 60 and older in each PSA is multiplied by a weight of 1.0 (Demonstration Column H).
   b. The number of minority persons aged 60 and older in each PSA is multiplied by a weight of 2.0 (Demonstration Column I).
   c. The number of low-income persons aged 60 and older in each PSA is multiplied by a weight of 2.0 (Demonstration Column J).
   d. The number of geographically isolated persons aged 60 and older in each PSA is multiplied by a weight of 1.5 (Demonstration Column K).
   e. The number of Medi-Cal eligible persons aged 60 and older in each PSA is multiplied by a weight of 1.0 (Demonstration Column L) for Title IIID only).
6. The total weighted population for each PSA is converted into a proportion of the total weighted population for all PSAs.
7. Each PSA's program allotments are determined in the following manner:
   a. For Title IIIB, C-1, and C-2 programs,
      i. Total State and federal program funds available are distributed to each PSA by multiplying each PSA's proportion or total weighted population by total statewide program allocation for Title III B, C and E.
      ii. Each PSA's program allotment is compared to its 1979 allotment level. If a PSA is under its 1979 level, it receives an allotment equal to its 1979 level in lieu of the computed allotment in 7.a.1.
      iii. The statewide program allocation is reduced by the total amount allocated to those PSAs receiving allotments equal to their 1979 level. The remaining statewide program allocation is then distributed to the remaining PSAs according to the formula to determine their adjusted total Title III B, C-1 and C-2 program allotments.
      iv. Total program funds for each PSA are then distributed to each Title III program as follows:
         1. Federal funds are distributed based on the proportion of funds received by CDA of the latest Notice of Grant Award from the Federal Government.
         2. State funds are distributed based upon the statewide totals included in the most recent Budget Act, or Budget bill if allocations impact the next budget year, or other relevant legislation.

b. For Title IIIE and VII program funds are allocated by multiplying each PSA's proportion of the total weighted population by the total statewide program allocation for each program, then distributing to fund sources as in 7.A.4.
c. For Title IIID, program funds are allocated by multiplying each PSA's proportion of the total weighted population, including Medi-Cal eligibles, by the total statewide program allocation for each program, then distributing to fund sources as in 7.A.4.

California Department of Aging

POPULATION DATA AND DEMONSTRATON OF ALLOCATION

	Population Data (Number of Persons) b/							Demonstration of IFF Allocation									
									Weighted Population = Weight x Number of Persons								
a/		c/ 60+	d/ 60+	e/ 60+ Low	f/ 60+ Geo.	g/ 60+ Medi-Cal	a/	Area Admin	1.0	2.0	2.0 Low	1.5 Geo.	1.0 Med-Cal	Title IIIB, C, E Weighted	Title IIID Weighted	Total Federal	a/
PSA	Pop 60 +	Non-Min.	Minority	Income	Isolation	Eligibles	PSA	Allocation	Non-Min	Minority	Income	Isolation	Eligibles	Total	Total	Allocation	PSA
Col>	A	B	C	D	E	F		G	H	I	J	K	L	M	N	O	
1	27,268	24,354	2,914	4,015	8,305	2,682	1	91,476	24,354	5,828	8,030	12,458	2,682	50,670	53,352	$557,637	1
2	63,292	57,436	5,856	7,500	25,015	5,671	2	146,269	57,436	11,712	15,000	37,523	5,671	121,671	127,342	1,221,250	2
3	72,479	64,872	7,607	9,150	21,420	7,116	3	160,243	64,872	15,214	18,300	32,130	7,116	130,516	137,632	1,316,229	3
4	330,758	246,472	84,286	31,945	31,205	34,513	4	553,094	246,472	168,572	63,890	46,808	34,513	525,742	560,255	5,175,213	4
5	52,045	46,850	5,195	2,830	2,140	2,197	5	129,162	46,850	10,390	5,660	3,210	2,197	66,110	68,307	668,696	5
6	144,080	60,788	83,292	24,690	0	35,725	6	269,150	60,788	166,584	49,380	0	35,725	276,752	312,477	2,725,061	6
7	160,913	112,632	48,281	12,275	2,670	13,576	7	294,754	112,632	96,562	24,550	4,005	13,576	237,749	251,325	2,355,635	7
8	124,356	80,780	43,576	8,305	1,460	12,703	8	239,150	80,780	87,152	16,610	2,190	12,703	186,732	199,435	1,859,591	8
9	210,954	103,821	107,133	24,530	1,235	33,078	9	370,868	103,821	214,266	49,060	1,853	33,078	369,000	402,078	3,644,333	9
10	256,552	159,313	97,239	20,370	3,320	38,285	10	440,224	159,313	194,478	40,740	4,980	38,285	399,511	437,796	3,941,991	10
11	87,033	56,032	31,001	12,615	9,970	12,621	11	182,380	56,032	62,002	25,230	14,955	12,621	158,219	170,840	1,571,560	11
12	40,908	37,600	3,308	3,805	24,980	2,167	12	112,222	37,600	6,616	7,610	37,470	2,167	89,296	91,463	886,513	12
13	44,976	35,543	9,433	4,350	6,090	4,020	13	118,410	35,543	18,866	8,700	9,135	4,020	72,244	76,264	729,051	13
14	136,768	85,038	51,730	20,310	24,920	23,331	14	258,029	85,038	103,460	40,620	37,380	23,331	266,498	289,829	2,636,717	14
15	66,179	42,713	23,466	10,670	12,715	12,011	15	150,660	42,713	46,932	21,340	19,073	12,011	130,058	142,069	1,290,000	15
16	6,824	5,919	905	740	3,025	430	16	60,380	5,919	1,810	1,480	4,538	430	13,747	14,177	394,561	16
17	120,433	99,710	20,723	11,485	12,500	8,512	17	233,183	99,710	41,446	22,970	18,750	8,512	182,876	191,388	1,816,097	17
18	129,208	78,910	50,298	9,840	3,180	11,274	18	246,530	78,910	100,596	19,680	4,770	11,274	203,956	215,230	2,009,895	18
19	881,474	466,397	415,035	111,270	9,140	156,387	19	1,390,751	466,397	830,070	222,540	13,710	156,387	1,532,717	1,689,104	15,149,377	19
20	232,268	131,455	100,813	28,955	18,930	29,550	20	403,287	131,455	201,626	57,910	28,395	29,550	419,386	448,936	4,128,879	20
21	317,113	238,345	78,768	32,580	21,670	26,262	21	532,339	238,345	157,536	65,160	32,505	26,262	493,546	519,808	4,834,839	21
22	437,972	305,593	132,379	36,445	550	48,249	22	716,170	305,593	264,758	72,890	825	48,249	644,066	692,315	6,345,117	22
23	441,298	314,106	127,192	44,540	18,845	48,385	23	721,229	314,106	254,384	89,080	28,268	48,385	685,838	734,223	6,839,474	23
24	21,516	7,273	14,243	4,600	4,405	7,090	24	82,727	7,273	28,486	9,200	6,608	7,090	51,567	58,657	524,604	24
25	587,649	310,931	276,760	95,125	1,150	135,380	25	943,834	310,931	553,520	190,250	1,725	135,380	1,056,426	1,191,806	10,338,283	25
26	33,200	29,049	4,151	4,535	13,565	3,574	26	100,498	29,049	8,302	9,070	20,348	3,574	66,769	70,343	676,033	26
27	87,780	76,820	10,960	7,310	12,145	5,343	27	183,516	76,820	21,920	14,620	18,218	5,343	131,578	136,921	1,317,511	27
28	93,782	56,950	36,832	6,720	7,370	7,741	28	192,646	56,950	73,664	13,440	11,055	7,741	155,109	162,850	1,553,758	28
29	31,517	28,673	2,844	2,255	10,895	1,514	29	97,938	28,673	5,688	4,510	16,343	1,514	55,214	56,728	545,243	29
30	70,227	51,071	19,156	9,075	6,595	10,368	30	156,818	51,071	38,312	18,150	9,893	10,368	117,426	127,794	1,168,854	30
31	29,886	18,862	11,024	4,760	5,305	5,383	31	95,458	18,862	22,048	9,520	7,958	5,383	58,388	63,771	585,800	31
32	58,236	38,139	20,097	5,655	7,475	6,504	32	138,579	38,139	40,194	11,310	11,213	6,504	100,856	107,360	1,008,503	32
33	108,223	62,251	45,972	15,210	13,840	12,998	33	214,611	62,251	91,944	30,420	20,760	12,998	205,375	218,373	2,021,040	33
	5,507,167	3,534,698	1,972,469	628,460	346,030	764,640		10,026,585	3,534,698	3,944,938	1,256,920	519,045	764,640	9,255,601	10,020,241	91,837,344	

VII Appendicies

Appendix A

OLDER AMERICANS ACT SECTIONS REFERENCED IN STATE PLAN

OAA SECTION	PROGRAM
Title III B	Supportive Services and Senior Centers. Encourages establishment of supportive services in the following program areas: transportation, health, mental health, housing, legal services, information and assistance, ombudsman, case management, security/crime, in-home services, community services, employment/second career, and consumer services.
Title III C	Nutrition Services. Provides grants for nutrition projects in congregate settings and home delivered meals to those who are homebound by reason of illness, disability, or isolation.
Title III D	Disease Prevention & Health Promotion Services. Provides for grants for periodic preventive health services to be provided at senior centers or alternative sites.
Title III E	National Family Caregiver Support Program. Provides grants to provide: information to family caregivers and grandparents raising grandchildren on the availability of support services; assistance in gaining access; individual counseling to help make decisions and solve problems; respite care and supplemental services.
Title V	Community Service Employment for Older Americans. Establishes an older American community service employment program to foster and promote useful part-time opportunities in community service activities for unemployed low-income persons age 55 and over who have poor employment prospects.
Title VII	Vulnerable Elder Rights Protection. Provides funding for states to develop Elder Rights Protections Systems focused on protecting the rights of vulnerable elders who reside in the community and in institutional settings.

Appendix B

State Plan Public Input Process

This Plan was developed with input from the Area Agencies on Aging and the California Commission on Aging. Both organizations provided input and early review of the draft Plan. CDA, in partnership with these two organizations, conducted two public hearings on the draft State Plan. The first public hearing was conducted on April 26, 2005 in Ontario, CA in conjunction with the Joint Leadership Conference of the California Association of Area Agencies and the California Foundation for Independent Living. The second public hearing was held on April 29, 2005 in Sacramento. XXX persons attended those public hearings. The draft plan was also posted on CDA's web site for XXX days for public input. XXX comments were received during the public comment period. This public input was incorporated into this final draft on the Plan. A summary of the hearing comments follows.

VII Endnotes

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